

Healthy Living and Longevity Medical Center

Function Higher—Physically, Mentally, Sexually®

11380 Prosperity Farms Road, #114, Palm Beach Gardens, FL 33410-3646

Telephone (561)842-7422 ~ hllmc.com ~

Patient Name: _____ Date: ____/____/____

Toxic Metals & Environmental Toxins Symptom Evaluation

Listed on the following pages are symptoms often found in patients who have absorbed excessive amounts of heavy metals and/or environmental toxins. These poisonous metals and chemicals are found in modern environments. Even if you have many of the symptoms below, you may not be heavy metal toxic or have environmental toxins. There may be other causes.

Directions: Check all that apply.

1. Signs, symptoms and disorders:

<input type="checkbox"/> Abdominal cramps	<input type="checkbox"/> Fingers or toes turn pale then blue	<input type="checkbox"/> Multiple chemical sensitivities, ie.: chemicals odors, medicines, nutritional supplements
<input type="checkbox"/> Allergies, asthma	<input type="checkbox"/> Fluid retention	<input type="checkbox"/> Muscle aching and weakness
<input type="checkbox"/> ALS (amyotrophic lateral sclerosis)	<input type="checkbox"/> Food allergies or sensitivities	<input type="checkbox"/> Muscle twitching
<input type="checkbox"/> Anemia	<input type="checkbox"/> Frequent urination at night	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Anxiety, irritability, or depression	<input type="checkbox"/> Headaches, frequent or migraine type	<input type="checkbox"/> Nausea or vomiting
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hearing loss, hearing difficulties	<input type="checkbox"/> Nervousness or jittery
<input type="checkbox"/> Attention Deficit Disorder-ADD/ADHD	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Neuropathy

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<input type="checkbox"/> Auto-immune disease	<input type="checkbox"/> High blood pressure*	<input type="checkbox"/> Numbness in the hands, arms, feet, or legs
<input type="checkbox"/> Bad breath, 'garlic breath'	<input type="checkbox"/> Increased heart rate	<input type="checkbox"/> Numbness or burning in mouth or gums
<input type="checkbox"/> Birth defects	<input type="checkbox"/> Infertility	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Bloating	<input type="checkbox"/> Infertility, poor sperm motility, or count	<input type="checkbox"/> Pale face or pale eyes
<input type="checkbox"/> Blurred vision or loss of vision	<input type="checkbox"/> Inflammation of the lining of the nose	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Brown spots or age spots on skin	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Pins and needles and nerve pain
<input type="checkbox"/> Burning of throat	<input type="checkbox"/> Irregular heart beat, arrhythmia	<input type="checkbox"/> Poor memory or memory lapses
<input type="checkbox"/> Burning pain (especially at night)	<input type="checkbox"/> Irritability	<input type="checkbox"/> Problems walking or balancing
<input type="checkbox"/> Cancer (particularly lung or skin)	<input type="checkbox"/> Irritable bowel/ colitis	<input type="checkbox"/> Protein in urine
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Itching a lot	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Chronic diarrhea	<input type="checkbox"/> Joint pain	<input type="checkbox"/> PVC's (cardiac arrhythmia caused by Raynaud's Syndrome (fingers or toes))
<input type="checkbox"/> Chronic fatigue, lack of energy	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Recurrent headaches
<input type="checkbox"/> Chronic headaches	<input type="checkbox"/> Learning disorders	<input type="checkbox"/> Recurrent infections
<input type="checkbox"/> Cold, clammy skin, especially hands or feet	<input type="checkbox"/> Leg cramps, frequently	<input type="checkbox"/> Ringing in the ears (tinnitus)
<input type="checkbox"/> Concentration difficulty	<input type="checkbox"/> Leucopenia	<input type="checkbox"/> Rocking movements

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<input type="checkbox"/> Confusion or forgetfulness	<input type="checkbox"/> Liver damage (diagnosed)	<input type="checkbox"/> Scleroderma
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Shaking or tremors
<input type="checkbox"/> Constipation, chronic	<input type="checkbox"/> Loss of sense of smell	<input type="checkbox"/> Shyness or timidity
<input type="checkbox"/> Difficulty talking	<input type="checkbox"/> Low blood pressure*	<input type="checkbox"/> Skin rashes
<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Lowered libido (less sex drive)	<input type="checkbox"/> Sleeping problems
<input type="checkbox"/> Emotional instability	<input type="checkbox"/> Lowered sperm production	<input type="checkbox"/> Sore gums (gingivitis)
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Lung irritation	<input type="checkbox"/> Stomach problems
<input type="checkbox"/> Exaggerated response to stimulation	<input type="checkbox"/> Lupus	<input type="checkbox"/> Tearing (eyes watering)
<input type="checkbox"/> Excessive salivation	<input type="checkbox"/> Many health problems, but “they say they can’t find anything wrong”	<input type="checkbox"/> Thirsty a lot
<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Metallic taste in mouth	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Eye irritation	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Tingling or pricking sensations
<input type="checkbox"/> Feeling cold when others don’t	<input type="checkbox"/> Mood swings	<input type="checkbox"/> TMJ (temporal mandibular joint) disorder
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> More colds or flu’s or infections than you think is normal	<input type="checkbox"/> White tongue or thrush

*high or low blood pressure problems are sometimes related to different metals.

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2. Have you worked in a 'sick building'? ___YES ___NO. If **yes**, do you have these symptoms?

<input type="checkbox"/> Congestion	<input type="checkbox"/> Headaches	<input type="checkbox"/> 'Scratchy throat'
<input type="checkbox"/> Decreased Attention Span	<input type="checkbox"/> 'Itchy Eyes'	<input type="checkbox"/> When you leave home or building the symptoms improve
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nausea	

3. Have you experienced increased respiratory tract infections?

<input type="checkbox"/> Colds	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sore Throats
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Sinus Infection	

4. Do you have these symptoms from sensitization and recurrent exposure to inhaled particles?

<input type="checkbox"/> Appetite Loss	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Dry Cough	<input type="checkbox"/> Shortness of Breath	

5. Mold exposure in home or office Yes No. If **yes**, do you have these symptoms?

<input type="checkbox"/> Chills	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nasal stuffiness
<input type="checkbox"/> Confusion	<input type="checkbox"/> Fever	<input type="checkbox"/> Respiratory problems
<input type="checkbox"/> Cough	<input type="checkbox"/> Headache	<input type="checkbox"/> Sleep disorders
<input type="checkbox"/> Depression	<input type="checkbox"/> Irritability	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Eye and / or skin irritation	<input type="checkbox"/> Muscular aches	

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6. Related to chronic exposure to Mycotoxins (products from Mold), do you have:

<input type="checkbox"/> Depression	<input type="checkbox"/> Immune Suppression	<input type="checkbox"/> Neurologic Disorders
<input type="checkbox"/> Hormone issues: Thyroid or Estrogen	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> New Cancer Diagnosis

7. Have you ever worked in manufacturing or fabricating of:

<input type="checkbox"/> Batteries	<input type="checkbox"/> Hot-type printing	<input type="checkbox"/> Plastics
<input type="checkbox"/> Electronics	<input type="checkbox"/> Metals	<input type="checkbox"/> Rubber
<input type="checkbox"/> Fiberglass	<input type="checkbox"/> Paper	<input type="checkbox"/> Textiles
<input type="checkbox"/> Glass ceramics	<input type="checkbox"/> Petroleum	

8. Have you been significantly exposed to:

<input type="checkbox"/> Alloys	<input type="checkbox"/> Fungicides	<input type="checkbox"/> Rodent killing chemicals
<input type="checkbox"/> Batteries	<input type="checkbox"/> Herbicides	<input type="checkbox"/> Wood preservatives
<input type="checkbox"/> Dyes	<input type="checkbox"/> Paints and thinners	
<input type="checkbox"/> Fertilizers	<input type="checkbox"/> Pesticides	

9. Have you done:

<input type="checkbox"/> Chemical processing	<input type="checkbox"/> Health service maintenance	<input type="checkbox"/> Metal smelting (copper, lead, manganese, zinc, etc.)
<input type="checkbox"/> Electroplating	<input type="checkbox"/> Leather tanning	<input type="checkbox"/> Photographic dark room work
<input type="checkbox"/> Fireworks	<input type="checkbox"/> Metal cutting	<input type="checkbox"/> Soldering, welding

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10. Have you ever lived or worked in or near a:

<input type="checkbox"/> Apple or peach orchard	<input type="checkbox"/> Coal-burning power plant	<input type="checkbox"/> Mercury mine
<input type="checkbox"/> Chloralkali plant	<input type="checkbox"/> Golf course	<input type="checkbox"/> Nickel refinery

11. Have you ever had Candida-related complex or yeast infections?

Candida-related complex is a cluster of symptoms which include:

<input type="checkbox"/> "Brain Fog"	<input type="checkbox"/> Fatigue/lethargy	<input type="checkbox"/> Irritability
<input type="checkbox"/> Constipation/diarrhea	<input type="checkbox"/> Food intolerances	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Depression	<input type="checkbox"/> Indigestion, bloating	

12. Have you ever had silver fillings in your teeth? Yes No

13. Have you ever worked in a dental office? Yes No

14. Do you take mineral supplements? Yes No

15. Do you use traditional or herbal medicines? Yes No

16. Do you eat seafood more than three times a month? Yes No

17. Do you smoke cigarettes? Yes No

Smoke now about ____ packs a day or week.

Have you quit? Yes (when)_____

If you smoked, how long? ____ About ____ packs a day week

Other tobacco use: pipe cigar snuff chew.

18. Are you exposed to second-hand smoke? Yes No

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19. Have you built a deck or other structure using pressure-treated lumber manufactured before 2003? Yes No

20. Do you get your water from a well? Yes No

21. Do you have old water pipes in your house? Yes No

22. Have you lived in a house built before 1978? Yes No

23. Have you ever renovated an old house? Yes No

24. Tell us about your Relative's Health

Has a blood relative had any of the following? (If Yes, show exact relationship: Your mother, father, sister, brother; your mother's mother, father, sister, brother, etc. If a person is adopted, please note that).

Disease or Illness: Relationship:

<input type="checkbox"/> Alzheimer's Disease/ dementia Relationship _____	<input type="checkbox"/> Cancer Relationship _____	<input type="checkbox"/> Mental problems Relationship _____
<input type="checkbox"/> Autism spectrum disorder Relationship _____	<input type="checkbox"/> Cardiovascular disease Relationship _____	<input type="checkbox"/> Parkinson's disease Relationship _____

25. Does your child have problems with intelligence, concentration, or language development? Yes No

26. I have "silver" dental fillings (amalgams) in my mouth. Yes No

27. I had amalgams but all are gone now, or were safely replaced with non-amalgams using International Academy of Oral Medicine & Toxicology standards. Yes No

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28. I had amalgams but all are gone now but were NOT replaced with safe dental techniques. Yes No
29. I had gold or nickel dental restorations at the same time as amalgams. Yes No
30. I have "Brain fog", where your thinking feels fuzzy and unfocused. Yes No
31. Tired nearly ALL the time – Chronic Fatigue Syndrome. Yes No
32. Cardiac (heart) problems such as arrhythmia (irregular heartbeat), congestive heart failure or angina? Yes No
33. Shortness of breath? Yes No
34. Autoimmune diseases such as Lupus, Fibromyalgia, Rheumatoid Arthritis? Yes No
35. Numbness, tingling, or paresthesia (burning, prickling, itching, with no apparent physical cause) of the skin or extremities? Yes No
36. Muscle twitching, tremors, balance problems, or restless leg syndrome? Yes No
37. Vision defects that are not explained by aging or correctable with eyeglasses? Yes No
38. Multiple Sclerosis, A.L.S. (Lou Gehrig's disease), Parkinson's disease? Yes No
39. Other chronic neurodegenerative disease? Yes No
40. Fear and/or panic attacks? Yes No
41. Depression or long periods of sadness and lack of joy and humor? Yes No
42. Lack of confidence? Yes No

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43. Rage or uncontrollable anger? Yes No
44. Schizophrenia? Yes No
45. Do you have low immune system issues such as recurring infections, HIV, or similar?
 Yes No
46. Been employed or worked in the Dental field (e.g. Dentist, Dental Assistant, etc.)?
 Yes No
47. Been exposed to mercury or its vapor through your work? Yes No
48. Lived near a coal-fired power plant? Yes No
49. Had seafood as a regular part of your diet (e.g., sushi, canned tuna, fresh tuna, swordfish, shark, kingfish)? Yes No
50. Gained weight without good reason? Yes No
51. Cold hands/feet, get cold easily, and/or dislike cold weather or air conditioning?
 Yes No
52. Lack of libido or poor sex drive or appetite? Yes No
53. Been told or suspected that you have a low thyroid condition? Yes No