Liver and Gallbladder Questionnaire

Name: _____ Date: _____

1.	Do you start to burp immediately after eating meals	1 2 3 4
2.	Do you have stomach upset by eating greasy foods	1 2 3 4
3.	Do you have a bitter and/or sour taste in mouth, especially after meals and/or in the mornings	1 2 3 4
4.	Do you have burping, belching, heartburn and/or gas	1 2 3 4
5.	Do you feel abdominal discomfort, nausea and/or indigestion when eating rich, fatty or fried foods	1 2 3 4
6.	Do you have greasy and/or shiny stools	1 2 3 4
7.	Does your stool color alternates from light or clay colored to normal brown colored	1 2 3 4
8.	Do you have pain at night that may move to your back or to your right shoulder	1 2 3 4
9.	Do you have pain between the shoulder blades	1 2 3 4
10.	Do you have headaches over the eye	1 2 3 4
11.	Do you experience throbbing temples and/or dull pain in the forehead after eating and/or with overeating	1 2 3 4
12.	Do you wake up regularly between 11:00pm – 3:00 am	1 2 3 4
13.	Do you experience pain and/or discomfort in the head, neck and / or body between 11:00pm – 3:00 am	1 2 3 4
14.	Do you experience fatique, weakness and/or exhaustion	1 2 3 4
15.	When massaging under your rib cage on your right side, is there pain, soreness and/or tenderness	Yes
16.	Do you have abdominal pain and/or discomfort with deep breathing	Yes
17.	Do you use NutraSweet (aspartame) and are bothered by using it.	Yes
18.	Do you have allergies	Yes
19.	Do you have hemorrhoids and/or varicose veins	Yes
20.	Do you have a general feeling of poor health	Yes
21.	Do you have a yellowish cast to your skin and/or eyes	Yes
22.	Do you retains fluid and feel bloated and/or swollen around the abdominal area	Yes
23.	Do you have a history of morning sickness	Yes
24.	Do you experience nausea and/or vomiting	Yes
25.	Do you experience sea, car, airplane sickness or motion sickness	Yes

26.	Are you frustrated, irritable, impatient, impulsive and/or easily angered	Yes
27.	Are you unable to concentrate and/or confused	Yes
28.	Do you have aching muscles not due to exercise	Yes
29.	Do you experience trembling hands	Yes
30.	Do you have a history of hepatitis and/or jaundice	Yes
31.	Do you have chronic fatique or fibromyalgia	Yes
32.	Have you experienced gallbladder attacks (past or present)	Yes
33.	Have you had your gallbladder removed	Yes
34.	Are you a recovering alcoholic	Yes
35.	Do you become sick if drinking wine	Yes
36.	If drinking alcohol, are you easily intoxicated	Yes
37.	Do you regularly consume more than two alcoholic beverages per day	Yes
38.	Do you experience hangovers after drinking alcohol	Yes
39.	Do you feel ill after ingesting small amounts of alcohol	Yes
40.	Do you have unexplained itchy skin worse at night	Yes
41.	Do you have skin rashes and/or other skin problems	Yes
42.	Do you have dry skin, itchy feet and/or skin peels on feet	Yes
43.	Do you have reddened skin, especially palms	Yes
44.	Do you have dry, flaky skin and/or hair (dandruff)	Yes
45.	Do you have a feeling of extreme dryness	Yes
46.	Are you on prescription medications	Yes
47.	Do you have a history of long term use of prescription medication and/or recreational drugs and/or alcohol abuse	Yes
48.	Do you regularly use tylenol, (acetaminophen) and/or paracetamol containing medications	Yes
49.	Do you use any hormone therapy in the form of birth control pills, progesterone, estrogen, prostate medications etc.)	Yes
50.	Are you currently taking an antacid such as cimetidine (Tagamet) or ranitidine (Zantac)	Yes
51.	Are you allergic to antibiotics such as (penicillin, sulpha drugs, tetracyclines etc).	Yes
52.	Are you more than 20 pounds over weight	Yes
53.	Do you have weight gain due to water retention	Yes
54.	Do you have a loss of appetite and/or weight loss	Yes

55.	Do you have swollen feet and/or legs	Yes
56.	Do you have dark urine with decreased flow	Yes
57.	Do you have vision (eye) problems and/or red, dry eyes	Yes
58.	Do you have bleeding tendencies in gums and/or nose	Yes
59.	Do you bruise easily	Yes
60.	Do you have bad breath and/or body odor	Yes
61.	Do you have a painful and/or tender big toe	Yes
62.	Do you sweat a lot	Yes
63.	Do you regularly consume more than four cups of coffee per day	Yes
64.	Have you recently used or do you regularly use tobacco products	Yes
65.	Do you have diabetes	Yes
66.	Have you had problems with ovarian cysts, fibroids and / or breast cancer	Yes
67.	Does your recent blood tests show abnormal enzymes or gallbladder function	Yes
68.	Is your total cholesterol over 200	Yes
69.	Do you have high LDL cholesterol levels (bad cholesterol)	Yes
70.	Do you have high triglycerides levels	Yes
71.	Are you sensitive to Monosodium glutamate (MSG)	Yes
72.	Are you sensitive to Sulphites (wine, dried fruit, or salad bar vegetables)	Yes
73.	Are you sensitive to foods containing the preservative sodium benzoate or potassium benzoate	Yes
74.	Are you sensitive to foods containg tyramine (red wine, cheese, bananas, or chocolate)	Yes
75.	Are you sensitive to foods or beverages containg caffeine	Yes
76.	Are you sensitive to Foods with onions or garlic in them	Yes
77.	Are you sensitive to Sensitive to tobacco smoke	Yes
78.	Are you sensitive to chemicals such as perfume, exhaust fumes, cleaning solvents, insecticides or strong odors	Yes
79.	Do you have you had a history of exposure to diesel fumes and/or toxic chemicals	Yes
80.	Do you have you had a history of exposure to chemicals such as herbicides, insecticides, pesticides or organic solvents	Yes

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