

Patient (your name, or if this is your child, the child's name)			
Patient's first name	Middle name	Last name	Last 4 digits of Soc. Sec. Number XXX-XX- _____

Instructions

Listed below are symptoms often found in patients who have absorbed excessive amounts of Heavy Metals: These poisonous metals include Lead, Mercury, Aluminum, Arsenic and Cadmium. All are found in modern environments.

Even if you have many of the symptoms below, you may not be Heavy Metal Toxic — there may be other causes. Certain combinations of symptoms are more accurate indicators.

The best available diagnostic tool to determine Heavy Metal Toxicity is a Urine Challenge Test for Heavy Metals. We offer this test through our office.

If you checked a dozen or more symptoms - or have significant exposures - you may have problems with Heavy Metals Toxicity. Visit our website, www.VaughanIntegrative.com, to make an appointment for a follow-up with a physician knowledgeable in Heavy Metals Toxicities.

Symptom List

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety or depression | <input type="checkbox"/> Lowered sperm production | <input type="checkbox"/> Many health problems, but "they say they can't find anything wrong." |
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Lowered libido (less sex drive) | <input type="checkbox"/> ALS (Amyotrophic Lateral Sclerosis) |
| <input type="checkbox"/> Learning disorders | <input type="checkbox"/> Eye irritation | <input type="checkbox"/> Cardiac problems |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Confusion or forgetfulness | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Lung irritation |
| <input type="checkbox"/> Numbness in hands, arms, feet or legs | <input type="checkbox"/> Excessive salivation | <input type="checkbox"/> Emotional instability |
| <input type="checkbox"/> Tingling or pricking sensations | <input type="checkbox"/> Tearing (eyes watering) | <input type="checkbox"/> Shyness or timidity |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Burning pain (especially at night) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rocking movements |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver damage (diagnosed) | <input type="checkbox"/> Burning in throat |
| <input type="checkbox"/> Auto-immune disease | <input type="checkbox"/> Infertility | <input type="checkbox"/> Inflammation of the lining of the nose |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Cancer (particularly lung or skin) | <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Loss of sense of smell | <input type="checkbox"/> Difficulty talking |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Metallic taste in mouth | <input type="checkbox"/> Abdominal cramps |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Thirsty a lot | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Pale face or pale eyes | <input type="checkbox"/> Chronic diarrhea |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Blurred vision, loss of vision | <input type="checkbox"/> Low blood pressure* |
| <input type="checkbox"/> Protein in urine | <input type="checkbox"/> Leukopenia | <input type="checkbox"/> High blood pressure* |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Bad breath, "Garlic Breath" | <input type="checkbox"/> Increased heart rate |
| <input type="checkbox"/> Nervousness (jumpy, jittery) | <input type="checkbox"/> Brown spots or age spots on skin | <input type="checkbox"/> Hearing loss, hearing difficulties |
| <input type="checkbox"/> Exaggerated response to stimulation | <input type="checkbox"/> PVC's (cardiac arrhythmia caused by Premature Ventricular Contractions) | <input type="checkbox"/> Chronic headaches |
| <input type="checkbox"/> Frequent urination at night | <input type="checkbox"/> Raynaud's Syndrome (fingers or toes turn pale, then blue) | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Chronic fatigue; lack of energy | <input type="checkbox"/> More colds and flu, or other infections, than you think is normal | <input type="checkbox"/> Cold, clammy skin, especially hands or feet |
| <input type="checkbox"/> Feeling cold when others don't | <input type="checkbox"/> Food allergies or sensitivities | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Numbness or burning in mouth or gums | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Constipation, chronic | <input type="checkbox"/> Problems walking or balancing | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Shaking or tremors | <input type="checkbox"/> White tongue (Thrush) | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Leg cramps, frequently | <input type="checkbox"/> Problems sleeping | <input type="checkbox"/> Fluid retention |
| <input type="checkbox"/> Muscle twitching | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Irritable bowel/colitis |
| <input type="checkbox"/> Ringing in the ears (tinnitus) | <input type="checkbox"/> Emotional instability | * High and Low Blood Pressure problems sometimes related to different metals. |
| <input type="checkbox"/> Itching a lot | | |
| <input type="checkbox"/> Sore gums (gingivitis) | | |
| <input type="checkbox"/> TMJ (temporal mandibular joint ailment) | | |

Patient (your name, or if this is your child, the child's name)						
Patient's first name		Middle name		Last name		Last 4 digits of Soc. Sec. Number XXX-XX- _____
Street address (not Post Office Box)			City	State	Zip Code	Date today MM/DD/YYYY
Date of Birth MM/DD/YYYY	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widow(er)ed <input type="checkbox"/> Partnered		
Guardian or Authorized Representative (If patient is under age 18 or adjudged incompetent.)						
If you are not the patient, check one: I am the patient's <input type="checkbox"/> legal next of kin <input type="checkbox"/> legal guardian <input type="checkbox"/> authorized representative.						
Guardian's/Rep's first name		Middle name		Last name		Last 4 digits of Soc. Sec. Number XXX-XX- _____
How can we reach you? (Check the telephone number you prefer us to call. We cannot discuss the results by email.)						
Work phone <input type="checkbox"/>	Extension	Home phone <input type="checkbox"/>	Mobile phone <input type="checkbox"/>	Best time to call	Email address	
Tell us about your work and environmental exposures. Check those that apply.						
Have you worked in manufacturing or fabricating <input type="checkbox"/> metals <input type="checkbox"/> plastics <input type="checkbox"/> petroleum <input type="checkbox"/> rubber <input type="checkbox"/> textiles <input type="checkbox"/> glass <input type="checkbox"/> ceramics <input type="checkbox"/> paper <input type="checkbox"/> electronics <input type="checkbox"/> hot-type printing <input type="checkbox"/> batteries <input type="checkbox"/> fiberglass?						
Have you been significantly exposed to <input type="checkbox"/> fertilizers <input type="checkbox"/> pesticides <input type="checkbox"/> rodenticides <input type="checkbox"/> herbicides <input type="checkbox"/> fungicides <input type="checkbox"/> paints and thinners <input type="checkbox"/> wood preservatives <input type="checkbox"/> batteries <input type="checkbox"/> alloys <input type="checkbox"/> dyes?						
Have you done health service maintenance <input type="checkbox"/> chemical processing <input type="checkbox"/> electroplating <input type="checkbox"/> soldering <input type="checkbox"/> welding <input type="checkbox"/> metal cutting <input type="checkbox"/> leather tanning <input type="checkbox"/> fireworks <input type="checkbox"/> metal smelting (copper, lead, zinc, etc.) <input type="checkbox"/> photographic darkroom work?						
Have you ever lived or worked near a <input type="checkbox"/> coal-burning power plant (like Belews Creek) <input type="checkbox"/> mercury mine <input type="checkbox"/> nickel refinery <input type="checkbox"/> golf course <input type="checkbox"/> chloralkali plant <input type="checkbox"/> phosphate mine <input type="checkbox"/> apple or peach orchard or tobacco farm?						
Have you ever had Candida-Related Complex (CRC) or yeast infections? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Have you ever had 10 or more silver-colored fillings in your teeth? <input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever worked in a dental office? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Do you <input type="checkbox"/> take mineral supplements <input type="checkbox"/> use traditional or herbal medicines <input type="checkbox"/> eat seafood more than three times a month?						
Do you smoke cigarettes? <input type="checkbox"/> Never smoked <input type="checkbox"/> Smoke now, about _____ packs a <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> Quit (when)						
If you smoked, how long? About _____ years. How much? About _____ packs a <input type="checkbox"/> day <input type="checkbox"/> week.						
Other tobacco use: <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Snuff <input type="checkbox"/> Chew Are you exposed to second-hand smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Have you built a deck or other structure, using pressure-treated lumber that was manufactured before 2003? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Do you get your water from a well? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you have old water pipes in your house? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Have you lived in a house built before 1978? <input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever renovated an old house? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Tell us about your relatives' health. Has a blood relative had any of the following? If so, check and show exact relationship: Your mother, father, brother or sister; your mother's mother, father, brother or sister; your father's mother, father, brother or sister. If _____ person adopted, note that.						
Disease or illness		Relationship		Disease or illness		Relationship
<input type="checkbox"/> Alzheimer's Disease, dementia				<input type="checkbox"/> Cardiovascular disease		
<input type="checkbox"/> Autism Spectrum Disorder				<input type="checkbox"/> Mental problems		
<input type="checkbox"/> Cancer				<input type="checkbox"/> Parkinson's Disease		
Does your child have problems with intelligence, concentration or language development? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Please sign below				Section below reserved for physician		
Your signature				Reviewed by physician (signature)		Date reviewed MM/DD/YYYY
If you checked a dozen or more symptoms — or have significant exposures — you may have problems with Heavy Metals Toxicity. Review at, www.VaughanIntegrativeMedicine.com , to see whether you wish to be further evaluated by us. Send completed questionnaire only after you have a confirmed appointment.				How to send us your completed questionnaire: 1. Print the form on your printer 2. Fax the form to (336) 808-3628 (Voice line: 808-3627) ...OR... 3. Mail the form to Vaughan Integrative Medicine, Suite A, 1301 W. Wendover Avenue, Greensboro, NC 27408		