Please fill out the following questionnaire before your allocated Telehealth Dr Medlab appointment. It should take you around 10 minutes to complete.
Once finished save the pdf and upload to your account page on medlabglobal.com here

Please note we cannot proceed with your online consultation until this form is completed and uploaded.

Dr Medlab Health Questionnaire

Personal Information

Full Name *

First Name Last Name

Height (cm)*

Weight (kg)*

Age *

Female-Male *

- (●) Female
- ( ) Male
- ( ) Transgender

Birth Date *

Address

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code | Country

E-mail *

Phone Number

Family Physician/Doctor and Phone #

Vitals

Blood Pressure *

Left Side | Right Side

Pulse

beats per min

Respirations

Basal Temperature

pH

Urine | Saliva

How many bowel movements do you have per day? *

What does your diet consist of?

Thyroid/Parathyroid (Glandular System)

Do you get cold hands and feet?

- ◯ Yes
- ◯ No

Is it easy to put on weight and hard to lose it?

- ◯ Yes
- ◯ No
- ◯ Maybe

Are your fingernails ridged, brittle or weak?

- ◯ Ridged
- ◯ Brittle
- ◯ Weak
- ◉ None of the above

Do you have varicose or spider veins?

- ◯ Yes
- ◯ No

Do you, or have you had hemorrhoids or prolapsed organs?

- ◯ Hemorrhoids
- ◯ Prolapsed organs
- ◯ No

Do you get cramping in your muscles?

- ◯ Yes
- ◯ No

Is your bladder strong or weak?

- ◯ Strong
- ◯ Weak

Do you have an irregular heartbeat?

- ◯ Yes
- ◯ No

Do you have Mitral Valve Prolapse (Heart Murmur)?

- ◯ Yes
- ◯ No

Do you get headaches or migraines?

- ◯ Yes
- ◯ No

Have you ever had a hernia?

- ◯ Yes
- ◯ No

Have you ever had an aneurysm?

- ◯ Yes
- ◯ No

Do you have osteoporosis?

- ◯ Yes
- ◯ No

Do you have scoliosis?

- ◯ Yes
- ◯ No

Do you get irritable easily?

- ◯ Yes
- ◯ No

Do you have low energy levels?

- ◯ Yes
- ◯ No

Do you suffer from symptoms of depression?

- ◯ Yes
- ◯ No

Did you score low on your bone density tests?

- ◯ Yes
- ◯ No
- ◯ N/A

Do your tests come back showing low Calcium levels?

- ◯ Yes
- ◯ No

Do you have, or have you ever had, a goiter?

- ◯ Yes
- ◯ No

Do you have spine deterioration, herniated discs, or bone spurs?

- ◯ Yes
- ◯ No

Have you been diagnosed with Hashimoto or Reidel disease? Has a family member?

- ◯ Yes
- ◯ No
- ◯ Family member

How much do you sweat?

- ◉ Low
- ◯ Medium
- ◯ A lot

Do your legs get tired or cramp after you walk?

- ◯ Yes
- ◉ No

Do you bruise easily? (parathyroid)

- ◯ Yes
- ◉ No

Pancreas

Do you get gas after you eat?

- ◯ Yes
- ◉ No

Do you feel your foods just sitting in your stomach?

- ◯ Yes
- ◯ No

Do you have Acid Reflux?

- ◯ Yes
- ◯ No

Do you see any undigested foods in your stools?

- ◯ Yes
- ◯ No

Are you thin and have a hard time putting on weight?

- ◯ Yes
- ◯ No

Do your foods pass right through you (diarrhea)?

- ◯ Yes
- ◯ No

Do you have moles on your body? (Adrenal & Pancreatic weakness)

- ◯ Yes
- ◯ No

Adrenal Glands

Medulla (Adrenal)

Are you overweight?

- ◯ Yes
- ◯ No

Do you have M.S., Parkinson's or Palsy?

- ◯ M.S
- ◯ Parkinson's
- ◯ Palsy
- ◯ No

Do you have anxiety attacks, or feel overly anxious?

- ◯ Yes
- ◯ No

Do you feel excessive shyness or inferior to others?

- ◯ Yes
- ◯ No

Do you have tremors, nervous legs, etc.?

- ◯ Yes
- ◯ No

Do you have High or Low Blood Pressure?

- ◯ High
- ◯ Low
- ◯ Average

Blood pressure: ex 120/60

Do you have hypoglycemia (low blood sugar)?

- ◯ Yes
- ◯ No

Do you have Diabetes (high blood sugar)?

- ◯ Yes
- ◯ Type I
- ◯ Type II
- ◯ No

Do you have tinnitis (ringing in the ears)?

- ◯ Yes
- ◯ No

Do you have shortness of breath or is it hard to take a deep breath?

- ◯ Yes
- ◯ No

Do you have heart arrhythmias?

- ◯ Yes
- ◯ No

Do you have a hard time sleeping or insomnia? (pineal)

- ◯ Yes
- ◯ No

Do you have Chronic Fatigue Syndrome?

- ◯ Yes
- ◯ No

Have you ever been diagnosed with Addison's Disease or Congenital Adrenal Hyperplasia?

- ◯ Yes
- ◯ Addison's
- ◯ Congenital Adrenal Hyperplasia
- ◯ No

Cortex (Adrenal)

Do you have elevated blood cholesterol levels?

- ◯ Yes
- ◯ No

Do you have arthritis, bursitis, or any inflammatory issues?

- ◯ Yes
- ◯ No
- ◯ Other

Do you have any "itis' (inflammatory conditions)?

- ◯ Yes
- ◯ No

Explain

Do you have low steroids or cortisol levels?

- ◯ Yes
- ◉ No

Females Only

Are your menstruation's irregular? (pituitary)

- Yes
- No

Do you get excessive bleeding during menstruation?

- Yes
- No

Do you have or have you had ovarian cysts?

- Yes
- No

Do you have or have you had fibroids?

- Yes
- No

Do you have or have you had endometriosis or A-typical cells?

- Yes
- No

Do you have or have you had fibrocystic breasts?

- Yes
- No

Do you get sore breasts, especially during menstruation?

- Yes
- No

Do you have a low or excessive sex drive?

- Low
- Excessive
- Average

Have you had a hysterectomy?

- Yes
- No

If yes, Date and State if Partial or Full

Did they take any other organs out at the same time? (ie gallbladder)

- ◯ Yes
- ◯ No

If yes, what other organs?

Have you had a D & C?

- ◯ Yes
- ◯ No

Have you had a miscarriage?

- ◯ Yes
- ◯ No

Have you had a difficulty conceiving children?

- ◯ Yes
- ◯ No

Have you been on Birth Control Pills?

- ◯ Yes
- ◉ No

If yes, for how long?

Are you currently pregnant?

- ◯ Yes
- ◯ No

Males Only

Do you have prostatitis (frequent urination esp. at night)?

- ◯ Yes
- ◯ No

Do you have prostate cancer?

- ◯ Yes
- ◯ No

If yes, What are your PSA counts?:

Do you have testicular hypertrophy (enlargement)?

- ◯ Yes
- ◯ No

Do you have a low or excessive sex drive?

- ◯ Low
- ◯ Excessive
- ◯ Average

Do you have erection problems?

- ◯ Yes
- ◯ No

Do you have premature ejaculation?

- ◯ Yes
- ◯ No

Gastro-Intestinal Tract

Do you have gastritis or enteritis?

- ◯ Yes
- ◯ No

Is your tongue coated (white, yellow, green, or brown), especially in the morning?

- ◯ Yes
- ◯ No

Do you have gastroparesis?

- ◯ Yes
- ◯ No

Do you have colitis?

- ◯ Yes
- ◯ No

Do you have diverticulitis?

- ◯ Yes
- ◯ No

Do you get or have diarrhea?

- ◯ Yes
- ◯ No

Do you get or have constipation?

- ◯ Yes
- ◯ No

have you ever had stomach or intestinal ulcers?

- ◯ Yes
- ◯ No

Do you or have you had any type of gastro-intestinal cancers? (stomach, colon, rectal, etc.)

- ◯ Yes
- ◯ No

If yes, explain:

Do you have Crohn's Disease?

- ◯ Yes
- ◯ No

Do you have "gas" problems?

- ◯ Yes
- ◯ No

Other GI problems:

Liver/Gallbladder/Blood

Do you have a problem digesting fats?

- ◯ Yes
- ◯ No

Do fats or dairy foods cause bloating and/or pain in the stomach area?

- ◯ Yes
- ◯ No

Are your stools white or very light brown in color?

- ◯ Yes
- ◯ No

Do you get pain behind the right, lower rib area?

- ◯ Yes
- ◯ No

Do you have "liver" or brown spots on your skin? (not freckles)

- ◯ Yes
- ◯ No

Are you jaundiced (yellowing of the skin)?

- ◯ Yes
- ◯ No

Do you have any skin pigmentation changes?

- ◯ Yes
- ◯ No

Are you or have you ever been anemic?

- ◯ Yes
- ◯ No

Do you have, or have you ever had, hepatitis?

- ◯ Yes
- ◯ No

If yes, please indicate A, B, or C:

Heart and Circulation

Do you get chest pains or angina?

- Yes
- No

Have you ever had a heart attack (Myocardial Infarction)?

- Yes
- No

Have you ever had open-heart surgery?

- Yes
- No

Do you have heart arrhythmia's?

- Yes
- No

If so, what kind?

Do you have a heart murmur or Mitral Valve Prolapse?

- Yes
- No

Do you ever feel pressure on your chest?

- Yes
- No

Do you get "prickly" pains anywhere, especially in the heart area?

- Yes
- No

If so, Where?

Do you have, or have you ever had High Blood Pressure? (kidneys)

- Yes
- No

Do you have a Pacemaker or Stints?

- ◯ Yes
- ◯ Pacemaker
- ◯ Stints
- ◯ No

Skin

Do you get or have skin rashes?

- ◯ Yes
- ◯ No

Do you get skin blemishes?

- ◯ Yes
- ◯ No

Do you have Eczema or Dermatitis?

- ◯ Yes
- ◯ No

Do you have Psoriasis?

- ◯ Yes
- ◯ No

Do you itch anywhere?

- ◯ Yes
- ◯ No

If so, where?

Is your skin:

- ◯ Dry
- ◯ Oily
- ◯ Both
- ◯ No

Do you have skin problems?

- ◯ Yes
- ◯ No

If so, what type:

Lymphatic System

Do you have hair loss or are you bald or going bald?

- ◯ Yes
- ◯ No

Have you ever had lymph nodes removed?

- ◯ Yes
- ◯ No

Do you have any gray hair?

- ◯ Yes
- ◯ No

Do you have a hard time remembering things?

- ◯ Yes
- ◯ No

Do you ever get colds or flu-like symptoms?

- ◯ Yes
- ◯ No

Do you have fibromyalgia or scleroderma?

- ◯ Yes
- ◯ No

Do you have or get sore throats?

- ◯ Yes
- ◯ No

Do you have swollen lymph nodes?

- ◯ Yes
- ◯ No

Do you have or have you had tumors?

- ◯ Yes
- ◯ No

If so, where?

Type ☐ Fatty ☐ Benign ☐ Malignant

Do you have a low platelet count (blood)?

- ◯ Yes
- ◯ No

Is your immune system weak or sluggish?

- ◯ Yes
- ◯ No

Have you had appendicitis or an appendectomy?

- ◯ Yes
- ◯ No

When?

Do you get boils, pimples, cysts, etc.?

- ◯ Yes
- ◯ No

Do you get regular exercise?

- ◯ Yes
- ◯ No

Exercise, how many times per week?

Have you ever had abscesses?

- Yes
- No

Have you ever had toxemia?

- Yes
- No

Do you have, or have you had, cellulitis?

- Yes
- No

Have you ever had gout?

- Yes
- No

Do you get blurred vision?

- Yes
- No

Do you have mucus in your eyes when you wake up in the morning?

- Yes
- No

Do you snore?

- Yes
- No

Do you have sleep apnea?

- Yes
- No

Have you had your tonsils out?

- Yes
- No

Kidneys and Bladder

Have you ever had a urinary tract infection (UTI's)?

- ◯ Yes
- ◯ No

Have you ever had "burning" upon urination?

- ◯ Yes
- ◯ No

Do you have problems holding your bladder? (parathyroid)

- ◯ Yes
- ◯ No

Have you ever had kidney stones?

- ◯ Yes
- ◯ No

Do you have bags under your eyes (esp. in the morning)?

- ◯ Yes
- ◯ No

Is your urine flow restricted?

- ◯ Yes
- ◯ No

Do you get cramping or pain on either side of your mid-to-lower back?

- ◯ Yes
- ◯ No

Do you or did you ever have nephritis?

- ◯ Yes
- ◯ No

Do you have lower back weakness?

- ◯ Yes
- ◯ No

Do you have or have you had sciatica?

- ◯ Yes
- ◯ No

Do you or did you ever have cystitis?

- ◯ Yes
- ◯ No

Lungs

Do you get or have (or have had) any of the following?:

- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ C.O.P.D.

Are you on inhalers or nebulizers?

- ◯ Yes
- ◯ No

How often?

What type?

Oxygen saturation level?

Do you get pain when you breathe?

- ◯ Yes
- ◯ No

Is it difficult to take a deep breath? (adrenals)

- ◯ Yes
- ◯ No

Did you ever or do you have lung cancer?

- ◯ Yes
- ◯ No

Are you a smoker?

- ◯ Yes
- ◯ No

If yes, of cigarettes or marijuana?

How much/ many per day?

Have you ever had pneumonia?

- ◯ Yes
- ◯ No

Have you ever worked around toxic chemicals, in coal mines, or around asbestos?

- ◯ Yes
- ◯ No

Do you cough a lot?

- ◯ Yes
- ◯ No

Do ou get any mucus when you cough?

- ◯ Yes
- ◯ No

What color is the mucus?

- ◯ Clear
- ◯ Yellow
- ◯ Green
- ◯ Brown
- ◯ Black

Environmental Toxins

Have you been vaccinated?

- ◯ Yes
- ◯ No

Have you had shots for traveling to foreign countries?

- ◯ Yes
- ◯ No

Have you had Flu shots?

- ◯ Yes
- ◯ No

Do you have mercury amalgams?

- ◯ Yes
- ◯ No

Do you find it difficult to take deep breaths?

- ◯ Yes
- ◯ No

Have you been exposed to any of the following:

- ☐ Nuclear Wastes or by-products
- ☐ Heavy Metals
- ☐ Chemicals

If yes to above, please elaborate:

Have you had radiation or chemotherapy?

- ◯ Radiation
- ◯ Chemotherapy
- ◯ No, I haven't

If so, how many treatments?

Chemical Medications

List any medications you are currently taking

Medication Names and Reason for taking:

Natural Supplements you are on currently

Allergies

Past Surgeries - major and minor, and the year

Genetic/Family Medical History

Mother

Father

Maternal Grandfather

Maternal Grandmother

Paternal Grandfather

Paternal Grandmother

Sister(s)

Brother(s)

You are almost done!!

What are your major health concerns (please list anything that was not addressed in this questionnaire):