The Diennet Institute

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Questionnaire A

The questions that are mandatory are marked with a * symbol

Basic Information

Last Name		Phone Number	
First Name		Mobile Number	
e-mail Address		Marital Status	
Gender	○ Male ○ Female	Kids	
Date of Birth		Profession	
		Height	

Current Address

Street		State/Province	
		ZIP	
City		Country	

Basic Information

What is your current weight? *	lbs
How much weight do you wish to lose? *	lbs

Lifestyle

- ☐ **A.** Sedentary
- ☐ **C.** Intellectual
- ☐ **E.** Tiring
- ☐ **D.** Interesting

- [ ] **B.** Manual (physically active)

1. Measurements

Measure and write-in your measurements for each area

A. Upper Arms *	inches	**E.** Buttocks *	inches	**H.** Calves *	inches
B. Chest *	inches	**F.** Thighs *	inches	**I.** Ankles *	inches
C. Waist *	inches	**G.** Knees *	inches	**J.** Neck *	inches
D. Hips *	inches				

2. Hereditary Illness

Is there a family history of the following:

- [ ] **A.** Obesity
- [ ] **B.** Heart trouble
- [ ] **C.** Hypertension
- [ ] **D.** Diabetes

Comments

3. Serious Illness

Have you had any of the following:

- [ ] **A.** Hypothyroid (low)
- [ ] **B.** Hyperthyroid (high)
- [ ] **C.** Heart trouble
- [ ] **D.** Pituitary tumor
- [ ] **E.** Asthma
- [ ] **F.** Allergies
- [ ] **G.** Ulcers
- [ ] **H.** Colitis
- [ ] **I.** Diabetes
- [ ] **J.** Tuberculosis
- [ ] **K.** Do you hear well?
- [ ] **L.** Kidney trouble

4. Surgical Operations

Have you had any of the following:

- [ ] **A.** Cancer or radiation

Type of Cancer _____ Date of cancer _____

- [ ] **B.** Appendectomy
- [ ] **E.** Thyroidectomy
- [ ] **H.** Pancreatectomy
- [ ] **C.** Hysterectomy
- [ ] **F.** Veinectomy
- [ ] **G.** Adrenalectomy
- [ ] **D.** Ovariectomy

Comments _____

5. Women

Monthly periods

A. Are your periods regular?	○ Yes ○ No
B. Do you suffer any pain during your period?	○ Yes ○ No
C. Do you feel bloated before your period?	○ Yes ○ No
D. Do you take any contraceptive pills or hormones such as progesterone or estrogen?	○ Yes ○ No
- 1. Are you bleeding between periods?	○ Yes ○ No
- 2. Do you think that you would need some hormones such as progesterone or estrogen?	○ Yes ○ No
E. Do you wear an IUD?	○ Yes ○ No
F. Have you ever had a miscarriage?	○ Yes ○ No
G. Have you ever had an abortion?	○ Yes ○ No
H. Have you been through menopause?	○ Yes ○ No
I. Do you have hot flashes?	○ Yes ○ No
J. Do you have any cysts in the breast?	○ Yes ○ No
K. Do you have any breast pain?	○ Yes ○ No
L. Do you suffer from premenstrual syndrome?	○ Yes ○ No

Comments _____

6. Blood circulation

A. Is your blood circulation normal? * ○ Yes ○ No

B. Do your legs feel heavy at night? * ○ Yes ○ No

C. Do your veins stand out (varicose veins)? * ○ Yes ○ No

D. Do you have any reaction to the sun? * ○ Yes ○ No

E. Do you tolerate heat? * ○ Yes ○ No

F. Do you tolerate cold? * ○ Yes ○ No

Comments

7. Personal Habits

A. Do you eat too much? * ○ Yes ○ No

B. Do you eat sweets? * ○ Yes ○ No

C. Are you a compulsive chocolate eater? * ○ Yes ○ No

D. Are you an obsessive eater? * ○ Yes ○ No

E. Do you snack between meals? * ○ Yes ○ No

F. Do you use any drugs? * ○ Yes ○ No

G. Do you have more than 3 drinks per day (wine or liquour)? * ○ Yes ○ No

Comments

8. Digestion

A. Do you have digestive problems? * ○ Yes ○ No

B. Do you feel sleepy after meals? * ○ Yes ○ No

C. Do you have any stomach pains? * ○ Yes ○ No

D. Do you have a hiatal hernia? * ○ Yes ○ No

E. Do you suffer from gas or flatulence? * ○ Yes ○ No

F. Do you have food allergies? * ○ Yes ○ No

Comments

9. Other Problems

A. Are you often constipated? * ○ Yes ○ No

B. Do you treat it in any way? * ○ Yes ○ No

Sexual Problems

C. Men: Impotence ○ Yes ○ No

D. Men: Premature ejaculation ○ Yes ○ No

E. Women: Frigidity ○ Yes ○ No

F. Women: Vaginal dryness ○ Yes ○ No

Vision-related Problems

G. Eye trouble: Myopia or presbyopia? * ○ Yes ○ No

Comments

10. Nervousness

A. Do you suffer from nervousness? * ○ Yes ○ No

B. Do you bottle everything up inside you? * ○ Yes ○ No

C. Do you let off steam easily? * ○ Yes ○ No

11. Anxiety

A. Are you a "worrier"? * ○ Yes ○ No

B. Do you smoke too much? * ○ Yes ○ No

C. Do you want to quit smoking? * ○ Yes ○ No

D. Do you have fits of laughing or dizziness (light headedness)? * ○ Yes ○ No

12. Depression

A. Are you often depressed? * ○ Yes ○ No

B. Do you cry often? * ○ Yes ○ No

C. Do you suffer from claustrophobia? * ○ Yes ○ No

D. Do you suffer from tetany or spasmophilia? * ○ Yes ○ No

13. Sleep

A. Do yo sleep well? * ○ Yes ○ No

B. Do you have nightmares? * ○ Yes ○ No

C. Do you take sleeping pills? * ○ Yes ○ No

D. Do you sleep too much? * ○ Yes ○ No

Comments

14. Weight History

Check the time period when you first gained excessive amount of weight and other times after. Check as many as apply:

- ☐ **A.** As an infant
- ☐ **B.** In grade school
- ☐ **C.** Just before puberty
- ☐ **D.** During puberty
- ☐ **E.** Just after puberty
- ☐ **F.** When you first had sexual relations
- ☐ **L.** Because of tuberculosis treatment
- ☐ **M.** After tuberculosis treatment
- ☐ **N.** After menopause
- ☐ **O.** Ater hysterectomy
- ☐ **P.** With the birth control pill
- ☐ **Q.** After an abortion
- ☐ **R.** After a miscarriage

- [ ] **G.** At time of marriage or change in lifestyle
- [ ] **H.** When your children were born
- [ ] **I.** During periods of emotional problems (illness of children, work problems, death of someone close, separation or divorce)
- [ ] **J.** When you had your tonsils or appendix removed
- [ ] **K.** As a result of thyroid or hormonal insufficiency
- [ ] **S.** After a corticoid treatment
- [ ] **T.** After long immobilization in bed
- [ ] **U.** After you quit smoking

15. Blood Test

Accurate blood test information is required. Your blood tests are valid for six months or one year.

A. Was your latest numeration blood test normal?	○ Yes	○ No
B. Is your blood sugar level high (over 110mg %)?	○ Yes	○ No
C. Is your cholesterol level high (over 250mg %)?	○ Yes	○ No
D. Is your urea level high?	○ Yes	○ No
E. Is your uric acid level high (over 60mg %)?	○ Yes	○ No

Comments

16. Other Tests

A. Do you have high blood preasure?	○ Yes	○ No
B. Do you have low blood pressure?	○ Yes	○ No
C. Is your thyroid higher than normal?	○ Yes	○ No
D. Is your thyroid normal?	○ Yes	○ No
E. Is your thyroid lower than normal?	○ Yes	○ No

Comments

17. Pulse

A. Is your pulse normal? * Yes No

B. Is your pulse too fast? * Yes No

18. Electrocardiogram

A. Was your last electrocardiogram normal? Yes No

B. Are you deficient in calcium? Yes No

C. Are you deficient in magnesium? Yes No

Comments

19. Medical Treatment

A. Are you presently under any medical treatment? *	○ Yes ○ No
B. If yes, are you taking any of the following:	
- a Antibiotics	○ Yes ○ No
- b. Diuretics	○ Yes ○ No
- c. Appetite suppressant	○ Yes ○ No
- d. Cardiac medication	○ Yes ○ No
- e. Cortisone medication	○ Yes ○ No
- f. Thyroid medication	○ Yes ○ No
- g. Hormone: Progesterone	○ Yes ○ No
- h. Hormone: Estrogen	○ Yes ○ No
- i. Other medications	○ Yes ○ No

20. Allergies

Allergies

21. Hormonal Levels

- **a** Progesteron	Low	Normal	High
- **b** Estrogen	Low	Normal	High
- **c** Testosterone	Low	Normal	High
- **d** Cortison	Low	Normal	High
- **e** Insulin	Low	Normal	High
- **f** Dopamine	Low	Normal	High
- **g** Melatonin	Low	Normal	High
- **h** Acethylcholine	Low	Normal	High
- **i** Growth Hormone	Low	Normal	High

FDA Requirements

By requirements of the FDA, please answer the following questions

Is there any medication you refuse to be in your prescription? * Yes No

If "yes", which one

Have you ever been on the Diennet Program * Yes No

If yes, when did you stop?

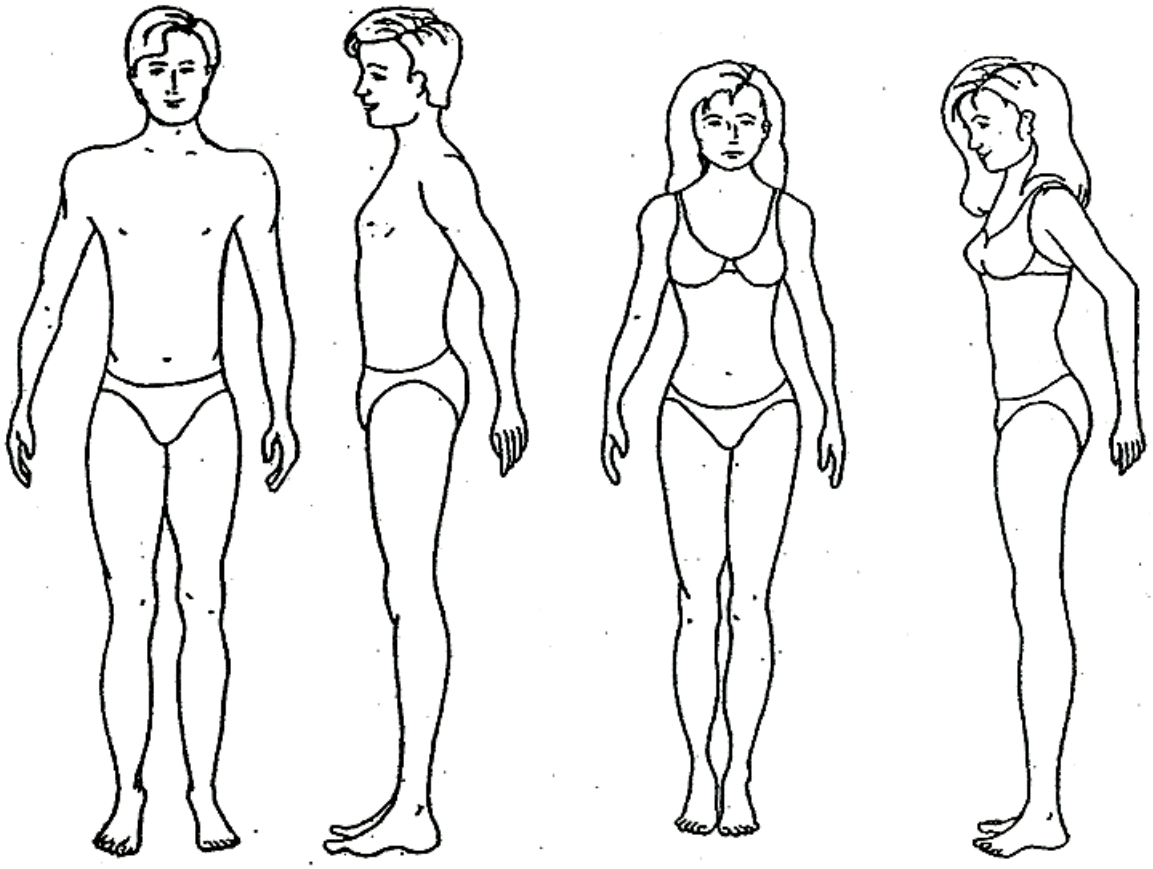
If yes, why did you stop?

Did you gain weight? Yes No

How much? Yes No

Why did you gain weight?

Please indicate on the drawing above the places where you have gained excessive weight



By submitting this questionnaire, I hereby certify that:

The above information is accurate and that I take full responsibility for following the guidelines of the program.

I understand that my medical and prescription information will not be disclosed to any other party, except upon my authorization.

I have read and agree with the Waiver and Consent Agreement.

Referred by	
Print your name	
Signature	
Date	