



## MELISA® pre-testing form

MELISA® tests for a Type-IV allergy to metal, which has been found in patients suffering conditions from Chronic Fatigue Syndrome to Multiple Sclerosis. It can be mild or acute and can manifest itself in many ways.

This form will allow us to make pre-testing diagnosis, checking for the classic signs of hypersensitivity and measuring your overall exposure to metals. This should give a preliminary indication of whether you may suffer a Type-IV metal allergy.

It also gives an idea which metals to test for, should you want to follow up with the MELISA® blood test, which uses a blood sample to pinpoint metal allergies and measure their scale.

Please fill in as many details as you can. If you don't know some of the dates, please give your estimate. The more accurate the data, the more accurate the diagnosis we can give you. It is in your own interest to fill in the form as honestly as possible.

If you need more space for the questions, please use extra sheets making clear which question you are responding to. Where there are alternatives to an answer, please put an X in the box of your choice. If you have any questions while filling in our pre-testing form, you can contact the MELISA® Foundation in Stockholm, Sweden. Contact information is found at the bottom of this form. *The questionnaire will be treated confidentially.*

### PERSONAL DETAILS

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Town: \_\_\_\_\_ Country: \_\_\_\_\_ Zip code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Current profession: \_\_\_\_\_

Past profession(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diagnosed disease, if any: \_\_\_\_\_

## 1. YOUR DENTAL RECORD

*Dental restorations are the most common cause of metal allergy; the more intimate exposure to metals such as mercury and gold, the greater the chance of becoming sensitised.*

### 1.1 CURRENT DENTAL FILLINGS

<i>Dental Material</i>	<i>Year of placement:</i>	<i>Number of fillings:</i>
Amalgam	_____	_____
Gold	_____	_____
Titanium	_____	_____
Composites	_____	_____
Metal-bound ceramic	_____	_____
Cobalt-crown	_____	_____
Non-metallic ceramic	_____	_____

### 1.2 ROOT FILLINGS

<i>Dental Material</i>	<i>Year of placement:</i>	<i>Number of fillings:</i>
Amalgam	_____	_____
Gutta-percha	_____	_____
Calcium hydroxide	_____	_____
Other: _____	_____	_____

1.3 Do you have any other implants in your mouth?

YES \_ NO \_

<i>Dental Material</i>	<i>Year of placement:</i>
Brånemark titanium with gold	_____
Brånemark titanium only	_____
Zirconium	_____
Other <i>please specify</i> _____	

1.4 Have you ever worn dentures or dental braces? YES \_ NO \_

If so, please give details \_\_\_\_\_

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### 1.5 REPLACING DENTAL FILLINGS

*Replacing fillings is a complex process, and there is a danger that some of the metal being removed or put in to the teeth can be released into the mouth. This can kick-start a metal allergy.*

a) Have you had your dental fillings replaced? YES \_ NO \_  
(If "no", go straight to question 1.11)

b) If so, please give details and the year of treatment

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c) Is the treatment complete or ongoing? COMPLETE \_ ONGOING \_

Name & location of Dentist (if known): \_\_\_\_\_

1.6 Which material did you change to?

Gold \_ Composite (plastic) \_

Ceramic (porcelain) \_ Metal-bound (MB) ceramic \_

Titanium Crowns \_ Other material (please specify) \_\_\_\_\_

**1.7** If you are in the process of changing your fillings, or have completed the treatment, did you feel any symptoms afterwards which you suspect may have been connected to the dental treatment? YES \_ NO \_

If so, what were the symptoms and how long did they last for?

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**1.8** Since replacing your fillings, have these symptoms improved or got worse?

*Short term:* Improved \_ Worsened \_ No real change \_

*Long term:* Improved \_ Worsened \_ No real change \_

**1.9** Since the restoration, have you suffered from oral burning, itching or irritation of tissue inside your mouth? YES \_ NO \_

*If so, when?* \_\_\_\_\_

**1.10** Since the restoration, have you observed any new symptoms you did not have before, such as eczema, tiredness, etc? YES \_ NO \_

*If yes, please specify* \_\_\_\_\_

**1.11** Do you gums bleed when you brush your teeth? YES \_ NO \_

If so, do they bleed every time? How much do they bleed?

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## **2. METAL EXPOSURE**

*Advances in science have introduced metals into a whole range of areas previously unthinkable from toothpaste to pacemakers inside the body. This section runs through some of the most common places metals are found.*

**2.1** Do you or did you have any metal in your body (implants, screws, pacemakers etc?)

*If so, please give details* \_\_\_\_\_

**2.2** Do you have any tattoos? YES \_ NO \_

If so, how many do you have and when did you get them done?

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2.3 Are you been ever exposed to metals in the work place? YES \_ NO \_

*Workplace exposure to metals is a common cause of metal hypersensitivity. Please give this question some thought. It can include everything from factory work to being in regular contact with mercury-containing thermometers.*

If so, what was your occupation, and, if possible, which metals were you exposed to?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(continue on separate page if necessary)

2.4 Is anyone in your family exposed to an unusually high amount of metals through their occupation? YES \_ NO \_

If so, please give details \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(continue on separate page if necessary)

## 2.5 SMOKING

a) Do you smoke? YES \_ NO \_

If so, how much? \_\_\_\_\_

How long have you been a smoker? \_\_\_\_\_

b) Have you smoked previously? YES \_ NO \_

How much did you used to smoke? \_\_\_\_\_

How long were you a smoker for? \_\_\_\_\_

c) Are you exposed to passive smoking at home or work? YES \_ NO \_

## 2.6 VACCINES

*Several vaccines contain metals, either as part of the preservative or as a residual trace from the production procedure. Manufacturers who use Thimerosal, for example, argue the mercury it contains is so small that it will not bring on a toxic effect. If you are hypersensitive, however, the smallest amount of mercury can trigger a reaction.*

a) Have you ever been given a Gamma globulin vaccine? (This is often used prior to travel, or as a boost to the immune system) YES \_ NO \_ UNSURE \_

b) Have you ever received a flu vaccine? YES \_ NO \_  
If so, what year? \_\_\_\_\_

c) Have you ever reacted badly to any vaccines in the past?  
If so, please give details \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ (continue on separate page if necessary)

### 2.7 EYE DROPS/ NOSE DROPS

*Many brands of contact lens solutions contain Thimerosal, a preservative which contains mercury.*

a) Do you currently use eye or nose drops? YES \_ NO \_  
b) Have you ever regularly used eye or nose drops? YES \_ NO \_

Please give the name of product, if you have it available, and how long you used it for.

\_\_\_\_\_  
\_\_\_\_\_

Did you notice any side-effects? YES \_ NO \_  
If so, give details \_\_\_\_\_

### 2.8 CONTACT LENSES

*Another source of Thimerosal*

a) Do you use soft contact lenses? YES \_ NO \_  
b) Have you ever used soft contact lenses? YES \_ NO \_

Which contact lens solution have you been using, and for how long?

\_\_\_\_\_  
Have you noticed any side-effects? \_\_\_\_\_

### 2.9 COSMETICS

*Most brands of make-up contain metal extracts of various kinds*

a) Do you use cosmetics? YES \_ NO \_  
If so, how often and which brands?

\_\_\_\_\_  
\_\_\_\_\_



\_\_\_\_\_ (continue on separate page if necessary)

**2.12 a)** Have you ever taken any injections for allergy treatment?

*Some people are treated with a dosage of the allergen - pollen, bee extract, etc, to build up long-term immunity.*

YES \_ NO \_

b) If so, please give details.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ (continue on separate page if necessary)

### **2.14 EVERYDAY ITEMS**

*Several confectionery (Smarties, Skittles etc) are coated with titanium to give them a crunchy coating. Most toothpaste also contains sodium lauryl sulphate (skin irritant) and titanium dioxide, which some people are hypersensitive to.*

a) Do you use chewing gum?

YES \_ NO \_

If so, what brand and how often do you use it?

\_\_\_\_\_

c) What brand of toothpaste do you use? \_\_\_\_\_

d) Do you eat crunchy-coated or multi-colour confectionery? YES \_ NO \_

If so, which brands? \_\_\_\_\_

### **2.15 PATCH TEST FOR METAL ALLERGY**

*This is a form of metal allergy testing, but as it involves placing metal against the skin, it can have side-effects.*

a) Have you ever done a skin test/patch test for metal allergy YES \_ NO \_

**(If "no", go straight to question 2.15)**

If so, please supply as many of the following details as you can:-

Name of doctor: \_\_\_\_\_

Clinic: \_\_\_\_\_

Test results: \_\_\_\_\_

\_\_\_\_\_ (continue on separate page if necessary)

b) Did you experience any changes in your health status following skin testing?

YES \_ NO \_

Which symptoms? \_\_\_\_\_

\_\_\_\_\_

**2.16** Do you live, or have you ever lived, close to anywhere likely to exude amounts of metal vapour? The classic examples include.

- Factories     Industrial plants     Freeways/motorways  
 Airports     Crematories     Dental office

*If so,*

Where? \_\_\_\_\_ When? \_\_\_\_\_

Where? \_\_\_\_\_ When? \_\_\_\_\_

Where? \_\_\_\_\_ When? \_\_\_\_\_

### **3. FOR WOMEN: (men go straight to section four)**

**3.1** Have you had ever had breast implants? YES \_ NO \_  
If so, what kind of implant and when was it fitted?

\_\_\_\_\_

**3.2** If you have given birth,

a) Do you belong to the RH-negative blood group? YES \_ NO \_  
b) Did you receive anti-RH-globulin after delivery? YES \_ NO \_

If so, when? \_\_\_\_\_

If you happen to know the date of treatment and name of the anti-RH-globulin product, please give details below.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **3.3** IU-devices

*This is a metal insert, often made of material which can kick-start a hypersensitive reaction.*

Have you ever used an IU device? YES \_ NO \_

If so, have you experienced discomfort using the IU device? YES \_ NO \_

*Please detail* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4. ALLERGIES AND ILLNESSES**

**4.1** Are you allergic to any antibiotics (penicillin, sulpha etc) YES \_ NO \_  
*If so, which one?* \_\_\_\_\_

**4.2** Do you have any food allergies? YES \_ NO \_  
*If so,*  
Which foods? \_\_\_\_\_

What are the symptoms? \_\_\_\_\_

When did you first notice the allergy? \_\_\_\_\_

**4.3** Do you have any other allergies? YES \_ NO \_  
*If so, please specify* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*(continue on separate page if necessary)*

**4.4** Do you have any diagnosed illness?  
Name of illness: \_\_\_\_\_

When was it diagnosed? \_\_\_\_\_

*If possible, please give the name and location of the diagnosing doctor.*

\_\_\_\_\_  
\_\_\_\_\_

Are there any special characteristics of your condition?

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*(continue on separate page if necessary)*

**4.5** Do you have any other symptoms, which have not been clearly diagnosed? If so, please supply details.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*(continue on separate page if necessary)*

**4.6 YOUR FAMILY HEALTH**

Please give details if any members of your family suffer any of the following. Please give full details on a separate page, if necessary.

a) Allergies: \_\_\_\_\_

\_\_\_\_\_

b) Autoimmune diseases: \_\_\_\_\_

c) Skin diseases: \_\_\_\_\_

d) Heart/artery diseases: \_\_\_\_\_

e) Diabetes: \_\_\_\_\_

f) Cancer/tumors: \_\_\_\_\_

g) Reactions to electro-magnetic fields (*such as photocopiers, microwave ovens, fluorescent tube lamps in shops*) \_\_\_\_\_

h) Chemical sensitivity: \_\_\_\_\_

i) Psychological illnesses: \_\_\_\_\_

j) Other: \_\_\_\_\_

**4.7 Are you currently taking any medication?**

*Some medication may bring on their own set of side-effects, which must be separated from signs of metal allergy. Also, some forms of medication may interfere with the MELISA® blood test. Patients should not be taking any immune suppressive drugs such as steroids when tested in MELISA® as this will affect the test results.*

If so, please give details, including period of treatment.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ (*continue on separate page if necessary*)

**4.8 Do you take vitamins or minerals supplements? If so, please give details.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



*For a donation of US\$50 your questionnaire will be reviewed by Prof. Vera Stejskal and the evaluation mailed back to you within 14 days. For maximum safety, please send your credit card information by fax.*

## **6. DONATION FORM**

*The MELISA® Medica Foundation is a not-for-profit organisation and all proceeds from this questionnaire go into our research. For this reason, we ask for a US\$50 donation rather, than charge a fee.*

### **Your credit card information**

Credit card company: Visa \_ MasterCard \_

Credit Card number: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Credit Card Expiration Date: month \_\_ year \_\_

I agree to let you debit US \$50 to my credit card as a donation to MELISA Diagnostics on behalf of the MELISA Medica Foundation. Please sign below.

\_\_\_\_\_ Place: \_\_\_\_\_ Date: \_\_\_\_\_

I want the evaluation of the questionnaire sent to me by: (please tick the box your choice.)

Mail \_ Fax \_ Email \_

If you are sending by fax or mail, we can contact you to confirm we have received your questionnaire intact. If you would like confirmation, please say below which email address we should contact, or telephone number we should call.

\_\_\_\_\_  
Please fax the questionnaire to MELISA Diagnostics:  
+44 20 8711 5958

*Or by post:*  
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