

Medical Questionnaire

NAME: _____

DATE: _____

ALLERGIES

Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us? _____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success		
					Excellent	Good	Fair
<i>Example: Post Nasal Drip</i>		X		<i>Elimination Diet</i>	X		
_____				_____			
_____				_____			
_____				_____			
_____				_____			
_____				_____			
_____				_____			

DISEASES/DIAGNOSIS/CONDITIONS Check appropriate box and provide date of onset

GASTROINTESTINAL

- Irritable Bowel Syndrome _____
- Inflammatory Bowel Disease _____
- Crohn's _____
- Ulcerative Colitis _____
- Gastritis or Peptic Ulcer Disease _____
- GERD (reflux) _____
- Celiac Disease _____
- Other _____

CARDIOVASCULAR

- Heart Attack _____
- Other Heart Disease _____
- Stroke _____
- Elevated Cholesterol _____
- Arrhythmia (irregular heart rate) _____
- Hypertension (high blood pressure) _____
- Rheumatic Fever _____
- Other _____

METABOLIC/ENDOCRINE

- Type 1 Diabetes _____
- Type 2 Diabetes _____
- Hypoglycemia _____
- Metabolic Syndrome _____
(Insulin Resistance or Pre-Diabetes)
- Hypothyroidism (low thyroid) _____
- Hyperthyroidism (overactive thyroid) _____
- Endocrine Problems _____
- Polycystic Ovarian Syndrome (PCOS) _____
- Infertility _____
- Weight Gain _____
- Weight Loss _____
- Frequent Weight Fluctuations _____
- Bulimia _____
- Anorexia _____
- Binge Eating Disorder _____
- Night Eating Syndrome _____
- Eating Disorder (non-specific) _____
- Other _____

CANCER

- Lung Cancer _____
- Breast Cancer _____
- Colon Cancer _____
- Ovarian Cancer _____
- Prostate Cancer _____
- Skin Cancer _____
- Other _____

GENITAL AND URINARY SYSTEMS

- Kidney Stones _____
- Gout _____
- Interstitial Cystitis _____
- Frequent Urinary Tract Infections _____
- Frequent Yeast Infections _____
- Erectile Dysfunction
or Sexual Dysfunction _____
- Other _____

MUSCULOSKELETAL/PAIN

- Osteoarthritis _____
- Fibromyalgia _____
- Chronic Pain _____
- Other _____

INFLAMMATORY/AUTOIMMUNE

- Chronic Fatigue Syndrome _____
- Autoimmune Disease _____
- Rheumatoid Arthritis _____
- Lupus SLE _____
- Immune Deficiency Disease _____
- Severe Infectious Disease _____
- Poor Immune Function _____
(frequent infections)
- Food Allergies _____
- Environmental Allergies _____
- Multiple Chemical Sensitivities _____
- Latex Allergy _____
- Other _____

RESPIRATORY DISEASES

- Asthma _____
- Chronic Sinusitis _____
- Bronchitis _____
- Emphysema _____
- Pneumonia _____
- Tuberculosis _____
- Sleep Apnea _____
- Other _____

SKIN DISEASES

- Eczema _____
- Psoriasis _____
- Acne _____
- Melanoma _____
- Skin Cancer _____
- Other _____

GYNECOLOGIC HISTORY *(for women only)*

OBSTETRIC HISTORY *Check box if yes and provide number of*

- Pregnancies _____ Caesarean _____ Vaginal deliveries _____
 Miscarriage _____ Abortion _____ Living Children: _____
 Post Partum Depression Toxemia Gestational Diabetes Baby over 8 pounds
 Breast Feeding For how long? _____

MENSTRUAL HISTORY

Age at first period: _____ Menses Frequency: _____ Length: _____ Pain: Yes No Clotting: Yes No

Has your period ever skipped? _____ For how long? _____

Last Menstrual Period: _____

Use of hormonal contraception such as: Birth Control Pills Patch Nuva Ring How long? _____

Do you use contraception? Yes No Condom Diaphragm IUD Partner vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

- Fibrocystic Breasts Endometriosis Fibroids Infertility
 Painful Periods Heavy periods PMS

Last Mammogram: _____ Breast Biopsy/Date _____

Last PAP test: _____ Normal Abnormal

Date of Last Bone Density _____ Results: High Low Within Normal Range

Are you in menopause? Yes No

Age at Menopause _____

- Hot Flashes Mood Swings Concentration/Memory Problems Vaginal Dryness Decreased Libido
 Heavy Bleeding Joint Pains Headaches Weight Gain Loss of Control of Urine Palpitations
 Use of hormone replacement therapy. How long? _____

MEN'S HISTORY *(for men only)*

Have you had a PSA done? Yes No

PSA Level: 0-2 2-4 4-10 > 10

- Prostate Enlargement Prostate infection Change in libido Impotence
 Difficulty Obtaining an Erection Difficulty Maintaining an Erection
 Nocturia (urination at night) How many times at night? _____
 Urgency/Hesitancy/Change in Urinary Stream Loss of Control of Urine

GI HISTORY

Foreign Travel? Yes No Where? _____

Wilderness Camping? Yes No Where? _____

Have you ever had severe: Gastroenteritis Diarrhea

Do you feel like you digest your food well? Yes No

Do you bloated after meals? Yes No

PATIENT BIRTH HISTORY

Term Premature

Pregnancy Complications: _____

Birth Complications: _____

Breast Fed How long? _____ Bottle-fed

Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____

Did you eat a lot of candy or sugar as a child? Yes No

DENTAL HISTORY

DENTAL SURGERY

Silver Mercury Fillings How many? _____

Gold Fillings Root Canals Implants Tooth Pain Bleeding Gums

Gingivitis Problems with Chewing

Do you floss regularly? Yes No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? Yes No

Are you happy? Yes No

Do you feel your life has meaning and purpose? Yes No

Do you believe stress is presently reducing the quality of your life? Yes No

Do you like the work you do? Yes No

Have you ever experienced major losses in your life? Yes No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? Yes No

Would you describe your experience as a child in your family as happy and secure? Yes No

STRESS/COPING

Have you ever sought counseling? Yes No

Are you currently in therapy? Yes No Describe: _____

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you can easily handle the stress in your life? Yes No

Daily Stressors: Rate on scale of 1-10

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation technique? Yes No How often? _____

Check all that apply: Yoga Meditation Imagery Breathing Tai Chi Prayer Other: _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes No

SLEEP/REST

Average number of hours you sleep per night: >10 8-10 6-8 < 6

Do you have trouble falling asleep? Yes No

Do you feel rested upon awakening? Yes No

Do you have problems with insomnia? Yes No

Do you snore? Yes No

Do you use sleeping aids? Yes No Explain: _____

ROLES/RELATIONSHIP

Marital status Single Married Divorced Gay/Lesbian Long Term Partnership

List Children:

Child's Name	Age	Gender

Who is living in Household? Number _____ Names _____

Their Employment/Occupation: _____

Resources for emotional support?

Check all that apply: Spouse Family Friends Religious/Spiritual Pets Other: _____

Are you satisfied with your sex life? Yes No

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At school				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? Yes No If yes, describe symptoms _____

Do you have any food allergies or sensitivities? Yes List all: _____ No

Do you have an adverse reaction to caffeine? Yes No

When you drink caffeine do you feel: Irritable or Wired Aches & Pains

Do you adversely react to: *Check all that apply:*

- Monosodium glutamate (MSG) Aspartame (NutraSweet) Caffeine Bananas Garlic Onion
 Cheese Citrus foods Chocolate Alcohol Red Wine
 Sulfite containing foods (wine, dried fruit, salad bars) Preservatives (ex. sodium benzoate)
 Other: _____

Which of these significantly affect you? *Check all that apply:*

- Cigarette Smoke Perfumes/Colognes Auto Exhaust Fumes Other: _____

In your work or home environment, are you exposed to: Chemicals Electromagnetic Radiation Mold

Have you ever turned yellow (jaundiced)? Yes No

Have you ever been told you have Gilbert's syndrome or a liver disorder? Yes No

Explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

- Herbicides Insecticides (frequent visits of exterminator) Pesticides Organic Solvents
 Heavy Metals Other: _____

Chemical Name, Date, Length of Exposure _____

Do you dry clean your clothes frequently? Yes No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? Yes No

Do you have any pets or farm animals? Yes No

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

GENERAL

- Cold Hands & Feet
- Cold Intolerance
- Low Body Temperature
- Low Blood Pressure
- Daytime Sleepiness
- Difficulty Falling Asleep
- Early Waking
- Fatigue
- Fever
- Flushing
- Heat Intolerance
- Night Waking
- Nightmares
- No Dream Recall

HEAD, EYES & EARS

- Conjunctivitis
- Distorted Sense of Smell
- Distorted Taste
- Ear Fullness
- Ear Pain
- Ear Ringing/Buzzing
- Lid Margin Redness
- Eye Crusting
- Eye Pain
- Hearing Loss
- Hearing Problems
- Headache
- Migraine
- Sensitivity to Loud Noises
- Vision problems (other than glasses)
- Macular Degeneration
- Vitreous Detachment
- Retinal Detachment

MUSCULOSKELETAL

- Back Muscle Spasm
- Calf Cramps
- Chest Tightness
- Foot Cramps
- Joint Deformity
- Joint Pain
- Joint Redness
- Joint Stiffness
- Muscle Pain
- Muscle Spasms
- Muscle Stiffness

Muscle Twitches:

- Around Eyes
- Arms Or Legs
- Muscle Weakness
- Neck Muscle Spasm
- Tendonitis
- Tension Headache
- TMJ Problems

MOOD/NERVES

- Agoraphobia
- Anxiety
- Auditory Hallucinations
- Black-out
- Depression

Difficulty:

- Concentrating
- With Balance
- With Thinking
- With Judgment
- With Speech
- With Memory
- Dizziness (Spinning)
- Fainting
- Fearfulness
- Irritability
- Light-headedness
- Numbness
- Other Phobias
- Panic Attacks
- Paranoia
- Seizures
- Suicidal Thoughts
- Tingling
- Tremor/Trembling
- Visual Hallucinations

EATING

- Binge Eating
- Bulimia
- Can't Gain Weight
- Can't Lose Weight
- Can't Maintain Healthy Weight
- Frequent Dieting
- Poor Appetite
- Salt Cravings
- Carbohydrate Craving (breads, pastas)
- Sweet Cravings (candy, cookies, cakes)
- Chocolate Cravings
- Caffeine Dependent

DIGESTION

- Anal Spasms
- Bad Teeth
- Bleeding Gums
- Bloating of:
 - Lower Abdomen
 - Whole Abdomen
 - Bloating after meals
- Blood in Stools
- Burping
- Canker Sores
- Cold Sores
- Constipation
- Cracking at Corner of Lips
- Cramps
- Dentures w/Poor Chewing
- Diarrhea
- Alternating Diarrhea and Constipation
- Difficulty Swallowing
- Dry Mouth
- Excess Flatulence/Gas
- Fissures
- Foods "Repeat" (Reflux)
- Gas
- Heartburn
- Hemorrhoids
- Indigestion
- Nausea
- Upper Abdominal Pain
- Vomiting
- Intolerance to:
 - Lactose
 - All Dairy Products
 - Wheat
 - Gluten (Wheat, Rye, Barley)
 - Corn
 - Eggs
 - Fatty Foods
 - Yeast
- Liver Disease/Jaundice
(Yellow Eyes or Skin)
- Lower Abdominal Pain
- Mucus in Stools
- Periodontal Disease
- Sore Tongue
- Strong Stool Odor
- Undigested Food in Stools

SKIN PROBLEMS

- Acne on Back
- Acne on Chest
- Acne on Face
- Acne on Shoulders
- Athlete's Foot
- Bumps on Back of Upper Arms
- Cellulite
- Dark Circles Under Eyes
- Ears Get Red
- Easy Bruising
- Lack Of Sweating
- Eczema
- Herpes-Genital
- Hives
- Jock Itch
- Lackluster Skin
- Moles w/Color/Size Change
- Oily Skin
- Pale Skin
- Patchy Dullness
- Rash
- Red Face
- Sensitive to Bites
- Sensitive to Poison Ivy/Oak
- Shingles
- Skin Darkening
- Strong Body Odor
- Hair Loss
- Vitiligo

ITCHING SKIN

- Skin in General
- Anus
- Arms
- Ear Canals
- Eyes
- Feet
- Hands
- Legs
- Nipples
- Nose
- Penis
- Roof of Mouth
- Scalp
- Throat

SKIN, DRYNESS OF

- Eyes
- Feet
 - Any Cracking?
 - Any Peeling?
- Hair
 - And Unmanageable?

- Hands
 - Any Cracking?
 - Any Peeling?
- Mouth/Throat
- Scalp
 - Any Dandruff?
- Skin In General

LYMPH NODES

- Enlarged/neck
- Tender/neck
- Other Enlarged/Tender
- Lymph Nodes

NAILS

- Bitten
- Brittle
- Curve Up
- Frayed
- Fungus-Fingers
- Fungus-Toes
- Pitting
- Ragged Cuticles
- Ridges
- Soft
- Thickening of:
 - Finger Nails
 - Toenails
- White Spots/Lines

RESPIRATORY

- Bad Breath
- Bad Odor in Nose
- Cough-Dry
- Cough-Productive
- Hoarseness
- Sore Throat

Hay Fever:

- Spring
- Summer
- Fall
- Change Of Season
- Nasal Stuffiness
- Nose Bleeds
- Post Nasal Drip
- Sinus Fullness
- Sinus Infection
- Snoring
- Wheezing
- Winter Stuffiness

CARDIOVASCULAR

- Angina/chest pain

- Breathlessness
- Heart Murmur
- Irregular Pulse
- Palpitations
- Phlebitis
- Swollen Ankles/Feet
- Varicose Veins

URINARY

- Bed Wetting
- Hesitancy (trouble getting started)
- Infection
- Kidney Disease
- Leaking/incontinence
- Pain/Burning
- Prostate Infection
- Urgency

MALE REPRODUCTIVE

- Discharge From Penis
- Ejaculation Problem
- Genital Pain
- Impotence
- Prostate or Urinary Infection
- Lumps In Testicles
- Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- Breast Cysts
- Breast Lumps
- Breast Tenderness
- Ovarian Cyst
- Poor Libido (Sex Drive)
- Vaginal Discharge
- Vaginal Odor
- Vaginal Itch
- Vaginal Pain with Sex
- Premenstrual:
 - Bloating Breast Tenderness
 - Carbohydrate Cravings
 - Chocolate Craving
 - Constipation
 - Decreased Sleep
 - Diarrhea
 - Fatigue
 - Increased Sleep
 - Irritability
- Menstrual:
 - Cramps
 - Heavy Periods
 - Irregular Periods
 - No Periods
 - Scanty Periods
 - Spotting Between