MEDICAL HISTORY QUESTIONNAIRE
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(Please Print Clearly)

Referred By:

NAME:		**Cell Phone:**
Address:		**Home Phone:**
City:	State: Zip:	
Date of Birth:	Sex: M / F	**Email:**
Occupation:		
Person to contact in case of Emergency:		Phone #:

Height: **Weight:** **Age:**

PRESENT HEALTH ISSUE:
What is your MAJOR complaint?

When did this condition begin?
What do you think caused this condition?

How often do you experience discomfort?

What increases or decreases your discomfort?

Has this problem occurred in the past?

How does this condition affect your daily activities?

If your condition is pain-related, rate the severity 1 through 10 (1 least severe/10 most severe):_____
What treatment(s) have you already received?

List any OTHER complaints currently bothering you:

1-	5-
2-	6-
3-	7-
4-	8-

When was the last time that you felt well?

Do you generally feel more hot or cold?

Do you have a Pacemaker?	Y / N
Do you have any surgical implants?	Y / N
Have you had a change in bowel or bladder habits?	Y / N
Do you have any unusual bleeding or dishcarge?	Y / N
Do you have indigestion or difficulty swallowing?	Y / N
Do you have any obvious change in a wart or mole?	Y / N
Do you have frequent falls?	Y / N

Do you have any labwork from the last 2 years? Y / N

WOMEN ONLY

Date of most recent menses _____
Cycles are every _____ days
Number of Pregnancies _____ Number of live births _____

Are you pregnant or breastfeeding?	Y / N
Have you had a D&C, hysterectomy or C-Section?	Y / N
Date of last Pap _____ Was the pap **Abnormal**:	Y / N
Heavy periods, irregularity, spotting, pain or discharge?	Y / N
Any signs of PMS?	Y / N
Any urinary tract, bladder, or kidney infections within the last year?	Y / N
Any blood in urine?	Y / N
Any hot flashes or sweating at night?	Y / N
Painful intercourse?	Y / N
Have you experienced recent breast lumps or nipple discharge?	Y / N

MEN ONLY

Do you feel pain or burning with urination?
Any blood in your urine?
Do you feel burning discharge from penis? Y / N If yes, how often _____

Has the force of your urination decreased?	Y / N
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Y / N
Any difficulty with erection or ejaculation?	Y / N
Any testicle pain or swelling?	Y / N
Date of last prostate exam _____	Y / N
Any sores on penis?	Y / N

PLEASE LIST ALL MAJOR CONDITIONS IN A <u>CRONOLOGICAL ORDER</u> FROM THE MOST RECENT TO YOUR CHILDHOOD.
The list should include present concerns, major illness/surgeries, any vaccinations apart from those in childhood, any other major events related to your health.
Please list them in order of occurance.

PAST AND FAMILY HISTORY

FAMILY HISTORY:

Has any blood relative ever had any of the following (include siblings, children, parents, grandparents)

Cancer	Diabetes
Heart Disease	Stroke
High Blood Pressure	Gout
Gastrointestinal	Female Issues
Skin	Other

List any other significant health problems or cause of death in the family

Have you had SURGERY/FRACTURE/HOSPITALIZATION: (please list procedure and date)

Have you had any Organ Removed (Gall Bladder, Appendix etc)?

CHILDHOOD ILLNESS: (*circle*) Measles / Mumps / Rubella / Chickenpox / Rheumatic Fever / Polio

List any MAJOR Illnesses as a child:

Were you <u>frequently</u> sick as a child (even if it was a common cold)? If Yes, please explain.

Have you had any illness as a result of Travels? If yes, please explain along with year.

Have you ever had food-poisoning? If yes, please explain along with year.

List any medication that you had to take for a longer time or more frequently in the past:
(antibiotics, pain medications, digestive issue medications, etc)

PLEASE CIRCLE ANY CONDITION WHICH YOU PRESENTLY HAVE OR HAVE HAD REOCCURING FREQUENTLY:

GASTROINTESTINAL
Poor Appetite
Bloating
Foul Breath
Diarrhea
Constipation
Excessive Hunger
Excessive Thirst
Gas
Hemorrhoids
Nausea/Vomiting
Vomiting Blood
Rectal Bleeding
Stomach Pain
Peptic Ulcer
Pancreatitis
Appendicitis
Acid Regurgitation
Intestinal Polyps

CARDIOVASCULAR
Chest pain
High blood pressure
Low blood pressure
Heart disease
Stroke
Palpitations
Swelling of ankles
Varicose Veins
High Cholesterol

RESPIRATORY
Chronic Sinus Congest
Allergies
Asthma
Bronchitis
Cough
Emphysema
Shortness of Breath
Common Cold
Sore Throat
Pneumonia

ENT
Bleeding gums
Nosebleeds
Blurred vision
Vision-floaters
Ringing in Ears
Earache
Ear Discharge
Hearing Loss
Hoarseness

SLEEP
Insomnia
Easily Awaken
Sleeping a lot

TRANSMITTED DISEASE
Mono
Herpes
Hepatitis
AIDS
HPV
Gonorrhea
Blood Transfusions

OTHER
Thyroid Disorder
Goiter
Diabetes
Liver Disease
Kidney Disease
Gout
Epilepsy/Seizure
Tumor/Cancer
Fibroids

AUTO-IMMUNE
Lupus
Parkinsons
Hashimoto's
Rheumatoid Arthritis
Multiple Sclerosis
Celiac Disease

MUSCLE/JOINT/BONE
Pain, weakness, numbness
injury in:

Neck	Hips	Ribs
Shoulder	Legs	Feet
Low Back	Chest	Hands

Arthritis
Artificial Joints

SKIN
Hives/Rash
Itching
Psoriasis
Eczema
Scars
Non-Healing sore
Acne

EMOTIONS
Anxiety
Depression
Moodswings
Anger/Fear/Sadness
Easily Sigh
Chemical Dependency
Anorexia
Easily Upset

GENERAL
Dizziness/Fainting
Forgetfullness
Foggy mind
Fatigue
Cold Hands/Feet
Twitching/Spasms
Hair Loss
Brittle Nails
Anemia
Weight Gain/Loss
Chills/Fever
Headaches/Migraines
Spontaneous Sweating
Water Retention
Decreased Sexual Drive
Stones (kidney/gall/urinary)
Drug/Alcohol Dependancy

EXPOSURE TO TOXINS

Please answer the following questions for past or present exposure:

	CIRCLE	DETAILS (amount, frequency, other)
Do you smoke cigarettes/marijuana?	Y / N	
Do you work or live with heavy smokers?	Y / N	
Do you use any recreational drugs?	Y / N	
Do you drink alcohol?	Y / N	
Have you received vaccines as a child?	Y / N	
Do you get the flu vaccine regularly?	Y / N	
Do you have amalgam (silver) fillings?	Y / N	
Have you had amalgam fillings removed?	Y / N	
Do you have root canals?	Y / N	
Have you been exposed to mold?	Y / N	
Are you exposed to any fumes at work?	Y / N	
Are you exposed to paint? (oil, acrylic, gouache, watercolor)	Y / N	
Do you eat large fish frequently? (tuna, swordfish)	Y / N	
Do you eat shellfish? (shrimp, crab, lobster, oyster)	Y / N	

What type of cookware do you use?
(nonstick, stainless steel, cast iron, clay)

Do you buy organic or conventional produce/food?

Which body products do you use?
(lotion, powder, toothpaste, deoderent, cleanser, makeup, etc)

Which hair products do you use?
(hair spray, hair gel, hair color, leave in conditioner, etc)

Please list all Vaccinations you have ever had as an adult (include HPV, flu, etc):

DIET

What does your Diet mainly consist of? (10=Daily 7=3xweek 4=1xweek 1=1xmonth 0=never)

Grains_____
(pasta, bread, rice, potato)

Vegetables_____
(not including salad greens)

Fruits_____

Meat_____
(beef, chicken, turkey, pork)

Salad_____
(green leafy)

Sweets_____
(processed)

Seafood_____
(fish, shrimp, lobster, crab)

Legumes_____
(lentils, beans)

Coffee_____

Dairy_____
(milk, cheese, yogurt)

Nuts/Seeds_____

Tea_____
(black, green, fruit)

Which spices do you MOST frequently cook with or order with your food?

_____Ginger
_____Garlic
_____Pepper
_____Rosemary
_____Basil
_____Parsley
_____Oregano
_____Salt
_____Turmeric
Other (please list):

What foods/drinks/tastes do you most crave?

What is the amount of Water you drink per day in ounces/liters?

Do you drink your water at room temperature or cold/iced?

Which OILS do you cook with?

Do you eat any of the following frequently:		**Frequency (x per day or week)**
Tomato	**Y / N**	
Potato	**Y / N**	
Eggplant	**Y / N**	
Bell Pepper	**Y / N**	
Hot Pepper	**Y / N**	
Dairy (milk, cheese, butter, yogurt, etc)	**Y / N**	
Peanuts/butter	**Y / N**	
Shellfish	**Y / N**	
Wheat/Gluten	**Y / N**	

Please List ALL MEDICATIONS/SUPPLEMENTS/VITAMINS that you use regularly or frequently:
(prescribed and over the counter)

MEDICATIONS: **SUPPLEMENTS/VITAMINS:**

Exercise (circle): Sedentary 1-2xweek 3-4xweek 6-7xweek

Share a SAMPLE MEAL on a work and non-work day in DETAIL:
(include oil, dressing, anything else added)
BREAKFAST

LUNCH

DINNER

SNACK