MEDICAL QUESTIONNAIRE

Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____

Work Phone: (_____) _____-_____ Birth Date: _____/_____/_____

Email: _____ Place of Birth: _____

City or town & country if not US

Referred by: _____

Height: ___' ____ " Weight: _____ Sex: _____

Today's Date _____

1. Please rank current/ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE THE TOP 3 HEALTH ISSUES	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
1.			
2.			
3.			

2. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister
   _____
   _____
   _____

3. Do you have any pets or farm animals? Yes____ No____
   If yes, where do they live? 1. _____ indoors 2. _____ Outdoors 3. _____ Both indoors and outdoors

4. Have you lived or traveled outside of the United States? Yes____ No____
   If so, when and where? _____
   _____

5. Have you or your family recently experienced any major life changes? Yes____ No____
   If yes, please comment: _____
   _____

6. Have you experienced any major losses in life? Yes____ No____
   If so, please comment: _____
   _____

7. Have you experienced any emotional or physical trauma/abuse in your lifetime? Yes____ No____
   _____
   _____
   _____

8. How important is religion or spirituality for you and your family's life?
   a. _____ not at all important
   b. _____ somewhat important
   c. _____ extremely important

9. How much time have you lost from work or school in the past year?
   a. _____ 0-2 days
   b. _____ 3 –14 days
   c. _____ > 15 days

10. Past Medical and Surgical History:

	ILLNESSES	WHEN	COMMENTS
	Anemia		
	Arthritis		
	Asthma		
	Autoimmune Disorder		
	Breast (Fibrocystic, Calcifications, Densities)		
	Bronchitis/Emphysema/Pneumonia		
	Cancer		
	Clotting Defects		
	Childhood Illness (i.e. rheumatic fever, chickenpox, mumps, measles, etc.)		
	Chronic Fatigue Syndrome		
.	Crohn's Disease or Ulcerative Colitis		
	Dental Issues		
	Depression/Anxiety		
	Diabetes (Type 1, Type 2)		
	Eating Disorder (Anorexia, Bulimia)		

Epilepsy, convulsions, or seizures		
Fibromyalgia		
Gallstones		
Gout		
Heart Disease, Attack/Angina/Failure		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel		
Kidney stones		
Liver Disease (Hepatitis, Fatty, Other)		
Osteoporosis/Osteopenia		
Sinusitis		
Sleep apnea		
Stroke		
Thyroid disease		
Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
Back injury		
Fracture / Right or Left		
Head injury		
Neck injury		
Other (describe)		
DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
Barium Enema		
Bone Scan		
CAT Scan (Location)		
Chest X-ray		
Colonoscopy/Sigmoidoscopy		
EKG		
MRI		
Thermogram		
Upper GI Series		
Other (describe)		

OPERATIONS	WHEN	COMMENTS
Appendectomy		
Cosmetic Surgery (Location)		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy (Partial or Total)		
Tonsillectomy		
Tubal Ligation		
Vasectomy		
Other (describe)		

11. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

12. How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

13. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

14. Are you allergic to any medications? Yes _____ No _____
If yes, please list with reactions:

_____
_____
_____
_____
_____

15. What medications are you taking now? Include non-prescription drugs.

Medication Name/Dose	Date started	Tolerance/Side Effects
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

16. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Supplement Name, Dose and Brand	Date started	Effective?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

17. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

18. As a child, were there any foods that you had to avoid because they gave you symptoms?

Yes____ No____

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)

_____

_____

_____

_____

19. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

20. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

21. Are you on a special diet? Yes____ No____

_____ GFCF _____ vegetarian _____ other (describe):
_____ Diabetic _____ vegan _____
_____ Dairy restricted _____ blood type diet _____

22. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain:
_____

23. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
Yes____ No____
b. If yes, are these symptoms associated with any particular food or supplement(s)?
Yes____ No____
c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.
_____
_____

24. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

25. Do you feel much **worse** when you eat a lot of :

_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other _____

26. Do you feel much **better** when you eat a lot of :

_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other _____

27. Does skipping a meal greatly affect your symptoms? Yes____ No____

28. Have you ever had a food that you craved or really "binged" on over a period of time? (Food craving may be an indicator that you may be allergic to that food.) Yes____ No____

    If yes, what food(s)? _____
    _____

29. Do you have an aversion to certain foods? Yes____ No____
    If yes, what foods? _____

30. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

31. Intestinal gas:
    _____Daily
    _____Occasionally
    _____Excessive
    _____ Present with pain
    _____ Foul smelling
    _____ Little odor

32. a. Have you ever used alcohol? Yes____ No____
    b. If yes, how often do you now drink alcohol?
    ___ No longer drinking alcohol
    ___ Average 1-3 drinks per week
    ___ Average 4-6 drinks per week
    ___ Average 7-10 drinks per week
    ___ Average >10 drinks per week

    c. Have you ever had a problem with alcohol? Yes____ No____
    If yes, please indicate time period (month/year): from _____ to _____.

33. Have you ever used recreational drugs? Yes____ No____
    Describe which ones and how long used
_____

34. Have you ever used tobacco? Yes____ No____
    If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
    If yes, what type of nicotine have you used? _____Cigarette _____ Smokeless
    _____Cigar _____Pipe _____Patch/Gum

35. Are you exposed to second hand smoke regularly? Yes____ No____

36. Do you have mercury amalgam fillings? Yes____ No____
    How many? _____ Are any of them bothering you?
_____

37. Do you have any root canals? Yes_____ No_____
    How Many? _____ Are any of them bothering you?
_____

38. Have your wisdom teeth or any other teeth been removed? Yes_____ No_____
    Any dry sockets or infections?
    _____

39. Have you ever worn braces? Yes_____ No_____
    Did you tolerate them without excessive mouth ulcers? Yes_____ No_____

40. Do you have any artificial joints or implants (include dental)? Yes____ No____

41. Do you feel worse at certain times of the year? Yes____ No____
    If yes, when? _____spring _____fall
    _____summer _____winter

42. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
    If yes, which one(s)? _____ lead _____cadmium
    _____arsenic _____mercury
    _____aluminum

43. Do or have you drank or bathed in well water? Yes____ No____
    How long? _____

44. Do odors affect you? Yes____ No____
    How?
_____

45. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

46. Have you ever had psychotherapy or counseling? Yes____ No____
Currently? _____ Previously? _____ If previously, from _____ to _____.
What kind? _____
Comments: _____

47. Are you currently, or have you ever been, married? Yes____ No____
If so, when were you married? _____ Spouse's occupation _____
When were you separated? _____ Never _____
When were you divorced? _____ Never _____
When were you remarried? _____ Never _____ Spouse's occupation _____
Comments: _____

48. Hobbies and leisure activities: _____
_____

49. Do you exercise regularly? Yes____ No____

If so, how many times a week?
1._____1x
2._____2x
3._____3x
4._____4x or more

When you exercise, how long is each session?
1._____ ≤15 min
2._____ 16-30 min
3._____ 31-45 min
4._____ > 45 min

What type of exercise is it?
_____Jogging/walking
_____Basketball
_____Home aerobics
_____tennis
_____water sports
_____other _____

50. FAMILY HISTORY: For each member of your family, follow the grey or white line across the page and check the boxes for:
1. Their present state of health, and
2. Any illnesses they have had.

*(Note: Except for **spouse**, Family refers to **blood** or **natural** relatives.)* **PRINT NAME/AGE BELOW**	Good Health	Poor Health	Deceased/ Cause	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Dis.	Nervous Breakdown	Rheumatism or Arthritis	Other
Father																		
Mother:																		
Brothers/Sisters:																		
Spouse:																		
Child:																		
Child:																		
Child:																		
Child:																		
Paternal relatives (in each box, write in how many affected with condition):																		
Maternal relatives (in each box, write in how many affected with condition):																		

50. Any other family history we should know about? Yes____ No____
If so, please comment: _____

51. What is the attitude of those close to you about your illness?
_____Supportive
_____Non-supportive

FOR WOMEN ONLY (questions 52-62):

52. Have you ever been pregnant? (If no, skip to question 51.) Yes____ No____
    Age at first pregnancy _____

    Number of miscarriages _____ Number of abortions _____ Number of preemies _____

    Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

    Did you develop toxemia (high blood pressure)? Yes____ No____

53. Have you had other problems with pregnancy or in trying to conceive? Yes____ No____
    If so, please comment: _____

    _____

54. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram_____
    Pap Smear: ___ Normal ___Abnormal Mammogram: ___ Normal ___ Abnormal

55. Menstruation
    Length of menstrual cycle _____ Number of days of flow _____
    Heaviness of flow_____
    Premenstrual symptoms? Yes____ No_____
    Starting and ending when _____
    Bleeding between periods? Yes____ No_____ Any pelvic pain, pressure or fullness? Yes____ No_____
    Any unusual vaginal discharge or itching? Yes____ No_____

56. In the last 2 weeks of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes____ No____ Not applicable _____
57. Are you sexually active or would you like to be? Yes____ No____

58. Have you ever used birth control pills? Yes____ No____ If yes, when/How long _____
    Are you taking the pill now? Yes____ No____
    Did/does taking the pill agree with you? Yes____ No____

59. Do you currently use contraception? Yes____ No____
    If yes, what type of contraception do you use? _____

60. Are you in menopause? No _____ Yes _____ If yes, age at last period_____
    Do you take synthetic hormones: Premarin? ___ Provera? ___ Other (specify) _____
    Do you take bioidentical hormones: Progesterone? ___ Estrogen? ___ Other (specify) _____
    _____

61. How long have you been on hormone replacement therapy (if applicable)? _____
62. Age mother in menopause? _____

63. Please check if these symptoms occur presently or have occurred in the past 6 months. Note location where applicable.

GENERAL:	Mild	Mod-erate	Severe
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Fatigue (AM/PM/Constant)			
Fever			
Flushing			
Heat intolerance			
Insomnia			
Nightmares			
No dream recall			
Weight Gain/Loss			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye dryness/crusting			
Eye pain			
Eyelid margin redness			
Headache (Migraine or Tension)			
Hearing loss			
Hearing problems			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	Mild	Mod-erate	Severe
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain / redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety / panic attacks			
Auditory hallucinations			
Black-out			
Depression / Low Mood			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headed			

MOOD/NERVES, Cont'd:	Mild	Mod-erate	Severe
Mood swings			
Numbness /Tingling			
Obsessive / compulsive			
Other Phobias			
Paranoia			
Seizures			
Suicidal thoughts/Plan			
Tremor/trembling			
Visual hallucinations			
EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
DIGESTION:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating			
Blood in stools			
Burping / belching			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Feels full too long after meal			
Farting			

DIGESTION, Cont'd:	Mild	Mod-erate	Severe
Fissures			
Heartburn/Reflux			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Stomach pain			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
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			

SKIN PROBLEMS, Cont'd:	Mild	Mod-erate	Severe
Eczema			
Hair Loss			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Mole w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			
Wheezing			

SKIN, DRYNESS OF:	Mild	Mod-erate	Severe
Feet cracking /peeling			
Hair dry/loss			
Hands cracking /peeling			
Mouth/throat			
Scalp dandruff			
Other			
LYMPH NODES:			
Neck enlarged/tender			
Other enlarged/tender lymph nodes			
NAILS:			
Bitten			
Brittle / soft			
Curve up / frayed			
Fungus - fingers / toes			
Pitting / ridges			
Ragged cuticles			
Thickening of: Finger nails / toenails			
White spots/lines			

RESPIRATORY:	Mild	Mod-erate	Severe
Bad breath			
Bad odor in nose			
Cough - dry / productive			
Hay fever: Season_____			
Hoarseness			
Nasal / Sinus stuffiness			
Nose bleeds			
Post nasal drip			
Shortness of breath			
Sinus infection			
Snoring			
Sore throat			

CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High/low blood pressure			
Mitral valve prolapse			
Palpitations/Irregular Pulse			
Phlebitis			
Rapid Heart Rate /Tachycardia			
Swollen ankles/feet /hands			
Varicose veins			

URINARY:	**Mild**	**Mod-erate**	**Severe**
Bed wetting			
Blood in urine			
Hesitancy /urgency			
Bladder Infection			
Kidney disease / stones			
Leaking/incontinence			
Nocturia (# times per night _____)			
Pain/burning			
Prostate enlargement			
Prostate infection			
PSA Level Normal?			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Erectile dysfunction /maintaining erections			
AM Erections?			
Infection			
Lumps in testicles			
Poor libido (sex drive)			

FEMALE REPRODUCTIVE:			
Breast cysts / lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Hot Flashes/Night Sweats			
Infertility			
Nipple discharge			
Painful intercourse			
Vaginal discharge			
Vaginal dryness			
Vaginal odor / itch			
Vaginal pain			
<u>Premenstrual:</u> Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
<u>Menstrual</u>: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Life Stress Questionnaire

During the past two years, have you had any of the following things happen to you? If so, simply circle one of the numbers following those items (and **only those items** that apply to you). Circle only one number after each event which has occurred in your life recently.

	LIFE EVENT	Slight	Moderate	Great
Example:				
	Change in social activities	10	15	20
	Change in sleeping habits	10	15	20
	Change in residence	10	15	20
1.	Change in social activities	10	15	20
2.	Change in sleeping habits	10	15	20
3.	Change in residence	10	20	30
4.	Change in work hours	15	20	25
5.	Change in church activities	15	20	25
6.	Tension at work	20	25	30
7.	Small children in the home	20	25	30
8.	Change in living conditions	20	25	30
9.	Outstanding personal achievement	25	30	35
10.	Problem teenager(s) in the home	25	30	35
11.	Trouble with in-laws	25	30	35
12.	Difficulties with peer group	25	30	35
13.	Son or daughter leaving home	25	30	35
14.	Change in responsibilities at work	25	30	35
15.	Taking over a major financial responsibility	25	30	35
16.	Foreclosure of mortgage of loan	25	30	35
17.	Change in relationship with spouse	30	35	40
18.	Change to different line of work	30	35	40
19.	Loss of a close friend	30	35	40
20.	Gain of a new family member	35	40	45
21.	Sex difficulties	35	40	45
22.	Pregnancy	35	40	45
23.	Change in health of family member	40	45	50
24.	Retirement	40	45	50
25.	Loss of job	45	50	55
26.	Change in quality of religious faith	45	50	55
27.	Marriage	45	50	55
28.	Personal injury or illness	45	50	55
29.	Loss of self confidence	55	60	65
30.	Death of a close family member	50	60	70
31.	Injury to reputation	50	60	70
32.	Trouble with the law	55	65	75
33.	Marital separation	55	65	75
34.	Divorce	65	76	85
35.	Death of spouse	80	100	120
36.	Other (invalid in family; drug or alcohol problem, etc): _____			
37.	Other: _____			
	Total of three columns	_____	_____	_____

Scoring System:

(1) Greater than 300, highly significant life stress
(2) 200-300, significant life stress
(3) 150-200, moderate life stress
(4) Less than 150, low life stress

POINT VALUE

Based on studies of Dr. Thomas Holmes,
University of Washington