

Medical Questionnaire



Name _____ **Date** _____ **Sex** M F **DOB** _____ **Age** _____

Blood Type _____ **Occupation** _____ **Last school grade completed** _____

Health Concerns. Please list in order of importance. Rate severity (1 is low severity, 10 is high) and success (1 is no success, 10 is very successful).

| Concern | Severity (1-10) | Past/Present Treatments | Success Level (1-10) |
|---------|-----------------|-------------------------|----------------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

Are you currently under the care of a physician? Yes No Specialty?

If yes, with whom? What condition?

If no, when did you last receive medical care?

When was your last physical exam? Prostate Exam:

Date of last Pap: Pelvic:

Do you have a known infectious disease at this time? Yes No

If yes, what?

Medications/Supplements

Please list all medications and vitamins/supplements you are currently taking in the following table:

Current

| Name | Strength | Dosage | Reason | Duration |
|---|----------|--------|--------|----------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| How much Calcium do you supplement daily? | | | Form? | |
| How much Magnesium do you supplement daily? | | | Form? | |

Past (Within last six months, circle any that apply)

Pain Relievers Blood pressure Sleeping

Antacids Hormones Steroids (cortisone, predisone)

Antibiotics Insulin Thyroid

Appetite suppressants Laxatives Tranquilizers

Birth control Sedatives Supplements:

How often have you taken antibiotics? Childhood? Adulthood?

Social History

With whom do you live? Pets? Indoor or outdoor? Farm animals?

Have you lived or traveled outside of the United States? If so, when and where?

Medical Questionnaire



| | | |
|-------------------|--|------|
| Typical Breakfast | | Time |
| Lunch | | Time |
| Dinner | | Time |
| Snacks | | |

| Food | Servings per Week | Food | Servings per Week |
|--------------------------|-------------------|--------------------------------|-------------------|
| Beef | | Fresh Fruit | |
| Poultry Light | | Fresh Vegetables | |
| Dark | | Breads, cereals, grains, pasta | |
| Lamb | | Legumes | |
| Fish | | Seeds | |
| Pork | | Nuts/Nut Butters | |
| Tofu/Soy Products | | Butter (sticks/week) | |
| Eggs (#/week) | | Oils: | |
| Yogurt %fat | | | |
| Protein Powder (type) | | | |
| Cottage Cheese %fat | | Sweets (cookies, cakes, candy) | |
| Cheese (oz servings) | | | |

Cravings? _____

Dietary restrictions or food aversions? _____

Time in between meals? _____

Main sources of protein? _____

Water intake: 8 oz. glasses/day

Do you purchase organic fruits and vegetables? Yes No Some

Do you purchase organic meat and dairy? Yes No Some

Beverages (specify type)

| | Yes | No | Past | Quantity/Week |
|------------------------------------|-----|----|------|---------------|
| Alcohol: | | | | |
| Coffee/Tea: | | | | |
| Soda: Diet Regular | | | | |
| Milk: %fat | | | | |
| Soy milk? | | | | |

Total pounds lost throughout your life dieting: _____

Do you use tobacco? Yes No Past Quantity: _____

Do you use recreational drugs? Yes No Type: _____ Quantity: _____

Do you exercise? Yes No What kind? _____ Frequency? Duration?

Interests and hobbies: _____

Do you watch television? Yes No Hours/Night? _____

Describe your work: _____

Do you take vacations? Yes No Week (s) off/year: _____

Do you have a supportive relationship? Yes No Married/Divorced/Single/Separated/Widowed

How important is spirituality or religion in your life? _____

Medical Questionnaire



Sleep:

| Hours/night | Yes | No | Past | Comments |
|--|-----|----|------|----------|
| Wake refreshed? | | | | |
| Fall asleep easily (within 5 minutes)? | | | | |
| Wake to urinate? | | | | |
| Wake at other time: | | | | |
| Do you snore? | | | | |
| Do you stop breathing during sleep? | | | | |

Energy (scale of 1-10, 10 is the best)

Stress (scale of 1-10, 10 is most severe)

Family History

| | Age if Living | Age of Death | Health Problems (please list any cancers, cardiovascular disease, diabetes, thyroid or osteoporosis) |
|----------------------|---------------|--------------|--|
| Mother | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Father | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |
| Siblings | | | |
| | | | |
| | | | |
| | | | |
| Spouse | | | |
| Children | | | Birth weight: |
| | | | Birth weight: |
| | | | Birth weight: |
| | | | Birth weight: |

Personal History

| <i>Childhood illnesses</i> | Yes, Had Disease | No, Never Had | Vaccinated |
|----------------------------|------------------|---------------|------------|
| Scarlet Fever | | | |
| Mumps | | | |
| Diphtheria | | | |
| Rheumatic Fever | | | |
| German Measles | | | |
| Measles | | | |

| <i>Childhood illnesses</i> | Yes, Had Disease | No, Never Had | Vaccinated |
|----------------------------|------------------|---------------|------------|
| Chicken Pox | | | |
| Shingles | | | |
| Smallpox | | | |
| Rubella | | | |
| Pertussis | | | |
| Other | | | |

Other Vaccinations (circle) Polio Tetanus Flu

Vaccination reactions? _____

Hepatitis B Meningitis HPV

Medical Questionnaire



Surgeries, Hospitalizations and Procedures

| Surgery | Year | Reason |
|--|------|-----------|
| Appendectomy | | |
| Tonsillectomy | | |
| Dental | | |
| Gallbladder | | |
| Hernia | | |
| Other | | |
| Do you have any artificial joints or other implants? Yes No Type? | | |
| Hospitalizations | Year | Reason |
| | | |
| | | |
| | | |
| Diagnostic Procedures | Year | Reason |
| Colonoscopy | | |
| Mammography | | |
| Ultrasound | | |
| X-Ray | | |
| DEXA (Bone Scan) | | |
| CT/MRI | | Location? |

Allergies

| | Type | Reaction |
|---------------|------|----------|
| Medications | | |
| Foods | | |
| Environmental | | |

Environmental History

Please indicate (X) if you have any current or past exposure to the items listed in the following table:

| Household | Current | Past | Reaction |
|-----------------------------------|---------|------|----------|
| Leaded paint | | | |
| Near refinery or industrial area | | | |
| New Carpet/Paint/Other Remodeling | | | |
| Pesticide/Insecticide Use | | | |
| Dry Cleaning | | | |
| Live in a Smoking Home | | | |
| Work | | | |
| Solvent Exposure | | | |
| Heavy Metals | | | |
| Fumes | | | |
| Chemicals | | | |
| Work in Smoking Environment | | | |

| Household | Current | Past | Reaction |
|---|---------|------|----------|
| Sensitivities | | | |
| Perfumes | | | |
| Detergents | | | |
| Gas or other Vapors | | | |
| Other | | | |
| Radiation | | | |
| Infectious | | | |
| Do you have metal or mercury fillings? Yes No | | | |
| Number? | | | |
| Done after 1976? Yes No | | | |
| Date of last filling: | | | |
| How many removed? | | | |
| Root canals currently? | | | |
| Root canals removed? | | | |

Please CIRCLE from the following options:

Yes (Y)= A condition you have **now** or in the **past 6 months**, No (N)=never had, Past (P)= A condition you had in the past (**longer than 6 months ago**)

| | | | | | | | | | | | |
|---|---|---|---|--------------------------|---|---|---|----------------------------|---|---|---|
| Cold Hands and Feet | Y | N | P | Loss of Balance | Y | N | P | Impaired Vision | Y | N | P |
| Daytime Sleepiness | Y | N | P | Fainting | Y | N | P | Eye Pain/Strain | Y | N | P |
| Difficulty Falling/Staying Asleep | Y | N | P | Lightheadedness | Y | N | P | Glasses/Contacts | Y | N | P |
| Early Waking | Y | N | P | Loss of Consciousness | Y | N | P | Tearing or Dryness | Y | N | P |
| Fever | Y | N | P | Nerve Pain | Y | N | P | Double Vision | Y | N | P |
| Flushing | Y | N | P | Tremor | Y | N | P | Glaucoma | Y | N | P |
| Sleepwalking | Y | N | P | Rash | Y | N | P | Cataracts | Y | N | P |
| Nightmares | Y | N | P | Eczema | Y | N | P | Eyelid Redness | Y | N | P |
| No Dream Recall | Y | N | P | Hives | Y | N | P | Vision Problems | Y | N | P |
| Snoring | Y | N | P | Acne | Y | N | P | Muscle Twitch in Eye | Y | N | P |
| Chronic Fatigue | Y | N | P | Boils | Y | N | P | Impaired Hearing | Y | N | P |
| Chronic Infection | Y | N | P | Itching | Y | N | P | ringing or Noise in Ear | Y | N | P |
| Enlarged/Tender Lymph Nodes | Y | N | P | Skin Color Change | Y | N | P | Earaches | Y | N | P |
| Slow Wound Healing | Y | N | P | Perpetual Hair Loss | Y | N | P | Dizziness | Y | N | P |
| Chemical/Metal/Drug Poisoning | Y | N | P | Head Lumps | Y | N | P | Ear Fullness | Y | N | P |
| Hyper/Hypo (circle) Thyroid | Y | N | P | Athletes Foot | Y | N | P | Other Ear Pain | Y | N | P |
| Hot/Cold (circle) Intolerance | Y | N | P | Cellulite | Y | N | P | Sensitivity to Loud Noise | Y | N | P |
| Night Sweats | Y | N | P | Dark Circles Under Eyes | Y | N | P | Frequent Sore Throats | Y | N | P |
| Hyper/Hypo (circle)glycemia | Y | N | P | Ears/Face (circle) Red | Y | N | P | Excess Saliva | Y | N | P |
| Diabetes | Y | N | P | Moles with Color or Size | Y | N | P | Dry Mouth | Y | N | P |
| Excess Thirst | Y | N | P | Shange | | | | Teeth Grinding | Y | N | P |
| Excess Hunger | Y | N | P | Oily Skin | Y | N | P | Gum Problems | Y | N | P |
| Fatigue | Y | N | P | Pale Skin | Y | N | P | Hoarseness | Y | N | P |
| Agoraphobia | Y | N | P | Psoriasis | Y | N | P | Sore Tongue | Y | N | P |
| Auditory/Visual (circle) Hallucinations | Y | N | P | Sensitive to Bites | Y | N | P | Coating on Tongue | Y | N | P |
| Treatment for Emotional Problem | Y | N | P | Shingles | Y | N | P | Loss of Taste | Y | N | P |
| Difficulty Concentrating | Y | N | P | Skin Cancer | Y | N | P | TMJ Problems | Y | N | P |
| Mood Swings | Y | N | P | Skin Darkening | Y | N | P | Teeth Problems | Y | N | P |
| Considered/Attempted (circle) Suicide | Y | N | P | Strong Body Odor | Y | N | P | Bleeding Gums | Y | N | P |
| Memory problems | Y | N | P | Thick Calluses | Y | N | P | Canker Sores | Y | N | P |
| Depression | Y | N | P | Vitiligo | Y | N | P | Cold Sores | Y | N | P |
| Anxiety/Nervousness | Y | N | P | Nails Bitten | Y | N | P | Cracking at Corner of Lips | Y | N | P |
| Panic Attacks | Y | N | P | Brittle | Y | N | P | Dentures | Y | N | P |
| Fearfulness | Y | N | P | Curve Up | Y | N | P | Periodontal Diseases | Y | N | P |
| Irritability | Y | N | P | Frayed | Y | N | P | Neck Lumps | Y | N | P |
| Phobias | Y | N | P | Fungus | Y | N | P | Swollen Glands | Y | N | P |
| Paranoia | Y | N | P | Pitting | Y | N | P | Goiter/Enlarged Thyroid | Y | N | P |
| Seizures | Y | N | P | Ragged Cuticles | Y | N | P | Neck Pain or Stiffness | Y | N | P |
| Paralysis | Y | N | P | Ridges | Y | N | P | Nose Stuffiness | Y | N | P |
| Muscle Weakness | Y | N | P | Thickening | Y | N | P | Sinus Fullness | Y | N | P |
| Numbness | Y | N | P | Toenail Problems | Y | N | P | Nose Bleeds | Y | N | P |
| Tingling | Y | N | P | White Spots/Lines | Y | N | P | Loss of Smell | Y | N | P |
| Loss of Memory | Y | N | P | Headache | Y | N | P | Sinus Infection | Y | N | P |
| Vertigo or Dizziness | Y | N | P | Migraine | Y | N | P | Postnasal Drip | Y | N | P |
| | | | | Tension Headache | Y | N | P | Bad Breath | Y | N | P |
| | | | | Head Injury | Y | N | P | Sore throat | Y | N | P |
| | | | | Concussion | Y | N | P | Odor in Nose | Y | N | P |
| | | | | Jaw/TMJ Problems | Y | N | P | Dry/Productive (circle) | Y | N | P |
| | | | | Eye Conjunctivitis | Y | N | P | Cough | | | |
| | | | | Crusting | Y | N | P | Sputum | Y | N | P |

