Integrative Health

# WELCOME TO OUR OFFICE

# Medical History Questionnaire

This is your medical history form, to be completed prior to your first visit with the Functional/Integrative physician. All information will be kept confidential. This information will be used for your evaluation. The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. Your answers will help us design a comprehensive program that meets your individual needs.

If you have questions or concerns, we will help you with those after this form is completed. We realize that some parts of the form will be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the medical history form.

Name: _____

Date: _____

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# MEDICAL HEALTH HISTORY

## General Information

**Patient:**

Name _____

Address _____

Contact phone numbers _____

Birth date _____

Email_____

Emergency contact Name: _____

Phone number: _____

**Family Physician and/or Primary Health Care Provider:**

Doctor/Other _____ Phone _____

Date of last complete physical examination: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

**Marital Status:**

☐ Single ☐ Married ☐ Divorced ☐ Widowed

**Sex:**

☐ Male ☐ Female

**Occupation:**

Position _____

**What is (are) your purpose (s) for consulting a Functional/Integrative physician?**

☐ To determine my current level of health and to receive recommendations for an individual health program.

☐ Specific health concerns/symptoms (please explain) _____

_____

_____

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List any additional health problems not listed: _____

_____

_____

_____

_____

## Medication and Supplementation Information

List all current medications first then list all supplements you have been taking within the last year. Attach a separate page if additional room is needed.

| **Medication** **Date:** | **Started** | **Stopped** | **Dosage daily** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Nutritional Supplements, Vitamins, Herbs, Homeopathic Remedies taken:**

_____

_____

_____

_____

_____

_____

**Medication Allergies**: _____

_____

Patient name: _____ Dob: _____ Date: _____

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**Environmental/Food Allergies**: _____

_____

**Women only answer the following:**

- ☐ Menstrual problems?
- ☐ Are you pregnant?
- ☐ Significant childbirth - related problems?
- ☐ Problems with sexual drive?
- ☐ Urine loss when you cough, sneeze or laugh?

Date of first menstrual cycle? _____

Date of last menstrual cycle? _____ Normal / Heavy / Regular / Irregular

Date of last Mammogram? _____ Normal / Abnormal

Do you perform monthly breast self-exams: Yes / No

Date of last Pelvic exam and / or Pap smear? _____ Normal / Abnormal

Date of last Pelvic and/or Transvaginal ultrasound? _____ Normal / Abnormal

Any sexually transmitted diseases? _____

Have you had a Bone Density/DEXA Scan? Yes / No Normal / Abnormal

How many pregnancies? _____ Number of children? _____ Delivery Vaginal / C-Section

Miscarriages: Yes / No If yes why? _____

Have you had a hysterectomy? Yes / No Were Ovaries Removed? Yes / No

If yes why? _____

**Comments:**

_____

_____

_____

Are you on or have been any type of hormone replacement therapy including birth control?

Yes / No

If yes what type and for how long? _____

_____

Patient name: _____ Dob: _____ Date: _____

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**Men only answer the following:**

- ☐ Problems with sexual drive and or erections
- ☐ Problems with urination (Decreased urine stream/Frequent urination at night)
- ☐ Problems with decreased muscle mass, tone or strength
- ☐ Problems with abdominal girth and increase in weight

Do you perform periodic testicular self-examinations? Yes / No

When was the last physical Prostate exam? _____ Normal / Abnormal

When was the lab work done for the prostate? _____ Normal / Abnormal

Have you had a prostate ultrasound? Yes / No Normal / Abnormal

Any sexually transmitted diseases? _____

Have you had your Testosterone level checked? Yes / No Normal / Abnormal

Have you had any hormone replacement therapy? Yes / No

If yes what type and for how long? _____

**Comments:**

_____

_____

## Screening tests

Colonoscopy? Yes / No Date: _____ Normal / Abnormal

EKG? Yes / No Date: _____ Normal / Abnormal

Cardiac Echo or Stress Test? Date: _____ Normal / Abnormal

X-ray? What part of the body? _____ Date: _____ Normal / Abnormal

List any **surgeries** you have had, including plastic surgery along with approximate date:

| Date | Type of Surgery |
|---|---|
| | |
| | |
| | |

Patient name: _____ Dob: _____ Date: _____

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# Family Medical History

For the conditions listed please include parents, siblings, aunts, uncles and grandparents:

| Contidition | Yes | No | Relationship |
|---|---|---|---|
| Arthritis | | | |
| Autoimmune Diseases (Lupus, RA, MS) | | | |
| Breast Cancer | | | |
| Colon Cancer | | | |
| Diabetes | | | |
| Digestive issues (IBS, Colitis, Crohn's) | | | |
| Elevated cholesterol | | | |
| Endocrine disorders (Thyroid, Adrenal) | | | |
| Genetic disorders | | | |
| Heart disease | | | |
| High blood pressure | | | |
| Liver disease (Hepatitis/Cirrhosis) | | | |
| Lung Diseases (Asthma, Emphysema) | | | |
| Mental Health (Depression, anxiety) | | | |
| Neurological Disorders (Alzheimer's, Parkinson's, Strokes, Dementia) | | | |
| Other cancer | | | |
| Ovarian / Uterine Cancer | | | |
| Prostate Cancer | | | |
| Skin Disorders (Psoriasis, Eczema) | | | |
| Stomach/Esophagus (Reflux/Ulcers) | | | |

Patient name: _____ Dob: _____ Date: _____

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# Personal Past Medical History

| Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|
| Depression | | | Bleeding Disorder | | |
| Emotional/Psychiatric Illness | | | Blood Clotting Problems | | |
| Diabetes (Insulin Resistance) | | | Cancer (type) | | |
| Seizure Disorder | | | Chest Pain | | |
| Herniated Disc(s) | | | Chronic Illness | | |
| Asthma | | | Constipation/Diarrhea | | |
| Headaches (Migraines) | | | Heart Disease | | |
| Chronic Bronchitis | | | Hepatitis/Liver Disease/Fatty Liver | | |
| Seasonal Allergies | | | High Blood Pressure | | |
| Osteoporosis/Osteopenia | | | Hormonal Imbalance | | |
| Recurrent Sinus Infections | | | Irregular Heartbeat | | |
| Lung/Breathing Problems | | | Kidney Disease/Stones | | |
| Fibromyalgia | | | Lupus / Sjogren's | | |
| Chronic Indigestion | | | Menstrual Disorders | | |
| Chronic Muscle / Joint Pain | | | Osteoarthritis | | |
| Neck Pain | | | Parkinson's / Alzheimer's | | |
| Intestinal Diseases (Crohn's, IBS) | | | Prostate Problems | | |
| Thyroid Disease | | | Psoriasis or Eczema | | |
| Stomach Ulcers (Gastritis) | | | Reproduction Problems | | |
| Obesity | | | Rheumatoid Arthritis | | |
| Skin Problems | | | Sexual/Libido Problems | | |
| Anxiety/Excessive Stress | | | Stroke/Vascular Disease | | |
| Back Pain/Sciatica | | | Tendonitis | | |

Patient name: _____ Dob: _____ Date: _____

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| GENERAL SYMPTOMS | 0 | 1 | 2 | 3 |
|---|---|---|---|---|
| ABDOMINAL / PELVIC PAIN | | | | |
| ACID REFLUX / HEART BURN | | | | |
| ANXIETY | | | | |
| ARTHRITIS | | | | |
| BACK PAIN / JOINT PAIN | | | | |
| BLOATING / FLATULENCE (GASSY) | | | | |
| BLOOD IN STOOL / URINE | | | | |
| BRUISE EASILY | | | | |
| CHEST PAIN / TIGHTNESS | | | | |
| COLD HANDS OR FEET | | | | |
| CONSTIPATION / DIARRHEA | | | | |
| DEPRESSION | | | | |
| DIZZY SPELLS / LIGHT HEADED | | | | |
| EXCESSIVE WORRYING | | | | |
| FATIGUE/WEAKNESS | | | | |
| HEADACHES / MIGRAINES | | | | |
| HEART RYTHM CHANGES (PALPITATIONS) | | | | |
| HIGH / LOW BLOOD PRESSURE | | | | |
| HOARSENESS / SORE THROAT / DRY MOUTH | | | | |
| INCREASE / DECREASE IN APPETITE | | | | |
| INCREASE / DECREASE IN WEIGHT | | | | |
| INCREASED SWEATING / NIGHT SWEATS | | | | |
| INSOMNIA | | | | |
| ITCHY SKIN | | | | |
| LACK OF ENERGY | | | | |
| LACK OF SELF ESTEEM | | | | |
| MOOD SWINGS | | | | |
| NAUSEA / VOMITING | | | | |
| NUMBNESS HANDS / FEET | | | | |
| ON GOING FEVER | | | | |
| PERSONALITY CHANGES | | | | |
| PROBLEMS WITH CONCENTRATION | | | | |
| REGULAR BOWEL MOVEMENTS | | | | |
| RESTLESS LEGS | | | | |
| SHORTNESS OF BREATH | | | | |
| SNORING | | | | |
| TREMBLING / TWITCHING | | | | |
| URINARY SYMPTOMS (FREQUENT/LEAKING) | | | | |
| VERICOSE VEINS | | | | |
| VISUAL / HEARING CHANGES | | | | |

Patient name: _____ Dob: _____ Date: _____

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| SYMPTOMS/LIFESTYLE QUESTIONS FOR MEN | | | | |
|---|---|---|---|---|
| **SYMPTOMS** | **NEVER** | **MILD** | **MODERATE** | **SEVERE** |
| ACNE | | | | |
| ATTENTION DEFICIT | | | | |
| BRITTLE / BREAKING NAILS | | | | |
| BURNED OUT FEELING | | | | |
| DECREASED ERECTIONS (DYSFUNCTION) | | | | |
| DECREASED FLEXIBILITY | | | | |
| DECREASED LIBIDO | | | | |
| DECREASED MENTAL SHARPNESS | | | | |
| DECREASED MUSCLE SIZE | | | | |
| DECREASED STAMINA | | | | |
| DECREASED URINE FLOW | | | | |
| HAIR LOSS | | | | |
| HOT FLASHES / FLUSHING | | | | |
| INCREASED URINARY URGE | | | | |
| INFERTILITY PROBLEMS | | | | |
| IRRITABLE / AGGRESSIVE | | | | |
| MENTAL FATIGUE / FORGETFULNESS | | | | |
| MORNING / EVENING FATIGUE | | | | |
| NERVOUS | | | | |
| OILY / DRY SKIN - HAIR | | | | |
| PAIN WITH URINATION | | | | |
| REGULAR BOWEL MOVEMENTS | | | | |
| RESTLESS LEGS | | | | |
| SENSITIVTITY TO CHEMICALS | | | | |
| SNORING | | | | |
| SORE MUSCLES | | | | |
| SWELLING / PUFFY | | | | |
| THINNING SKIN | | | | |
| | | | | |
| | | | | |
| | | | | |

Patient name: _____ Dob: _____ Date: _____

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| SYMPTOMS/LIFESTYLE QUESTIONS FOR WOMEN | | | | |
|---|---|---|---|---|
| **SYMPTOMS** | **NEVER** | **MILD** | **MODERATE** | **SEVERE** |
| ACNE | | | | |
| ATTENTION DEFICIT | | | | |
| BLEEDING CHANGES | | | | |
| BRITTLE / BREAKING NAILS | | | | |
| DECREASED FLEXIBILITY | | | | |
| DECREASED LIBIDO | | | | |
| DECREASED MENTAL SHARPNESS | | | | |
| DECREASED STAMINA | | | | |
| DEPRESSION | | | | |
| HAIR LOSS | | | | |
| HOT FLASHES | | | | |
| INCREASED ACHES / PAINS | | | | |
| INCREASED BODY / FACIAL HAIR | | | | |
| INFERTILITY PROBLEMS | | | | |
| IRRITABLE / AGGRESSIVE | | | | |
| MENTAL FATIGUE / FORGETFULNESS | | | | |
| MORNING / EVENING FATIGUE | | | | |
| NERVOUS / ANXIOUS | | | | |
| OILY / DRY SKIN – HAIR | | | | |
| PAINFUL / TENDER BREASTS | | | | |
| PAINFUL INTERCOURSE | | | | |
| PELVIC PAIN | | | | |
| RAPID AGING / THINNING SKIN | | | | |
| SENSITIVTITY TO CHEMICALS | | | | |
| SORE MUSCLES | | | | |
| SUGAR / SALT CRAVINGS | | | | |
| SWELLING / PUFFY | | | | |
| THINING SKIN | | | | |
| URINARY SYMPTOMS (LEAKING) | | | | |
| VAGINAL DRYNESS | | | | |
| | | | | |
| | | | | |
| | | | | |

Patient name: _____ Dob: _____ Date: _____

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## Social History / Personal Health Habits

| | | | | |
|---|---|---|---|---|
| My health is: | Excellent | Good | Fair | Poor |
| My Nutrition intake is: | Excellent | Good | Fair | Poor |
| My Physical fitness is: | Excellent | Good | Fair | Poor |
| My stress level is: | A lot of stress | often fatigued | Sad/Blue | Trouble dealing with stress |

Do you practice meditation/stress reducing techniques? Yes / No

**Dietary Habits**:

| | | | |
|---|---|---|---|
| No special diet | Avoid red meats | Minimize fats | Minimize carbs |
| Vegetarian | Emphasize fruits/vegetables | Try to eat healthy | Avoid Dairy/cheese |

**I commonly consume the following**:

Coffee Soft drinks Diet drinks Candy/chocolate Chip/crackers

I often eat at fast food restaurants: Yes / No
I often eat pre-packaged foods: Yes / No

Do you usually use oil or margarine in place of high cholesterol shortening or butter?

☐ Yes ☐ No

Do you usually abstain from extra sugar usage?

☐ Yes ☐ No

Do you usually add salt at the table?

☐ Yes ☐ No

Do you eat differently on weekends as compared to weekdays?

☐ Yes ☐ No

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**Exercise Habits**:

I do not routinely exercise:
If not what keeps you from exercising? _____

I routinely exercise:
If yes what type of exercise and how many times per week? _____

Aerobic exercise strength training swim/dance Flexibility (yoga/tai chi)

List Routine hobbies / sports / recreational activities: _____

_____

**Tobacco History**:

- o I have never smoked cigarettes or chewed tobacco.
- o I now smoke _____ packs per day. I have smoked _____ years
- o I quit smoking in _____ (Mo/yr). I smoked _____ packs/day for _____ years
- o I smoke cigars / pipe

**Alcohol History**:

- o I never drink alcohol
- o I drink occasionally or socially
- o I regularly drink _____alcoholic drinks/per day (this includes glasses of wine)
- o I have a family history of alcoholism

Patient Signature: _____ Date: _____

A 48 hour notice of cancellation is required. If a cancellation is less than 48 hours, you do not show or are over a half an hour Late for your appointment a rescheduling fee will be added to your next visit. We thank you for complying with this policy that has been proven to be very successful in helping us to care for patient needs.

Patient name: _____ Dob: _____ Date: _____