



## 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: \_\_\_\_\_

Patient name: \_\_\_\_\_ Dob: \_\_\_\_\_ Date: \_\_\_\_\_



## **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) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient name: \_\_\_\_\_ Dob: \_\_\_\_\_ Date: \_\_\_\_\_



List any additional health problems not listed: \_\_\_\_\_

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## 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.

<u>Medication</u>	<u>Date:</u>	<u>Started</u>	<u>Stopped</u>	<u>Dosage daily</u>

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

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Medication Allergies: \_\_\_\_\_

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Patient name: \_\_\_\_\_ Dob: \_\_\_\_\_ Date: \_\_\_\_\_



**Environmental/Food Allergies:** \_\_\_\_\_

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**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:**

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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? \_\_\_\_\_

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Patient name: \_\_\_\_\_ Dob: \_\_\_\_\_ Date: \_\_\_\_\_



**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:**

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**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:

<u>Date</u>	<u>Type of Surgery</u>

Patient name: \_\_\_\_\_ Dob: \_\_\_\_\_ Date: \_\_\_\_\_



## Family Medical History

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

<u>Contidition</u>	<u>Yes</u>	<u>No</u>	<u>Relationship</u>
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: \_\_\_\_\_

## Personal Past Medical History

<u>Condition</u>	Yes	No	<u>Condition</u>	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: \_\_\_\_\_

# Integrative Health

<b>GENERAL SYMPTOMS</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
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: \_\_\_\_\_



<b>SYMPTOMS/LIFESTYLE QUESTIONS FOR MEN</b>				
<b>SYMPTOMS</b>	<b>NEVER</b>	<b>MILD</b>	<b>MODERATE</b>	<b>SEVERE</b>
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				
SENSITIVITY TO CHEMICALS				
SNORING				
SORE MUSCLES				
SWELLING / PUFFY				
THINNING SKIN				

Patient name: \_\_\_\_\_ Dob: \_\_\_\_\_ Date: \_\_\_\_\_

<b>SYMPTOMS/LIFESTYLE QUESTIONS FOR <u>WOMEN</u></b>				
<b>SYMPTOMS</b>	<b>NEVER</b>	<b>MILD</b>	<b>MODERATE</b>	<b>SEVERE</b>
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				
SENSITIVITY TO CHEMICALS				
SORE MUSCLES				
SUGAR / SALT CRAVINGS				
SWELLING / PUFFY				
THINNING SKIN				
URINARY SYMPTOMS (LEAKING)				
VAGINAL DRYNESS				

Patient name: \_\_\_\_\_ Dob: \_\_\_\_\_ Date: \_\_\_\_\_



## 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

Patient name: \_\_\_\_\_ Dob: \_\_\_\_\_ Date: \_\_\_\_\_



**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:**

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

**Alcohol History:**

- I never drink alcohol
- I drink occasionally or socially
- I regularly drink \_\_\_\_\_ alcoholic drinks/per day (this includes glasses of wine)
- 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: \_\_\_\_\_