Adult Medical Questionnaire

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. 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. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will help us formulate a treatment plan.

First Name: _________________ Middle Name: _______________ Last Name: ____________________

Address: ______________________________ City: _________________ State: _______ ZIP: _________

Home Phone: (________) ________-___________ Birth Date: _____/____/____ Age: _________
month day year

Work Phone: (________) ________-___________ Cell Phone: (________) ________-___________

Email: __________________________________

Place of Birth:_____________________________ (city and state; provide country if outside U.S.)

Occupation: ___________________________ Height: ___′ ____ ″ Weight: _______ Sex: _____

How did you hear about our practice? ____

Social Security Number _______________ Medical Insurance Co.: ____________________________

Group # _________________ Contract # _______________

Today's Date _____________________

1. Please check appropriate box(es):

□ African-American	□ Hispanic	□ Mediterranean	□ Asian
□ Native American	□ Caucasian	□ Northern European	□ Other

2. Reason for visit: ____

____

3. Please list current problems in order of priority, and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Postnasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

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

5. Do you have any pets or farm animals? ☐ Yes ☐ No
   If yes, where do they live? ☐ Indoors ☐ Outdoors ☐ Both indoors and outdoors

6. Have you lived or traveled outside of the United States? ☐ Yes ☐ No
   If so, when and where? ______________________________
   ____

7. Have you or your family recently experienced any major life changes? ☐ Yes ☐ No
   If yes, please comment: ______________________________
   ____

8. Have you experienced any major losses in life? ☐ Yes ☐ No
   If so, please comment: ______________________________
   ____

9. How important is religion (or spirituality) for you and your family's life?
   ☐ Not at all important
   ☐ Somewhat important
   ☐ Extremely important

10. How much time have you lost from work or school due to illness in the past year?
    ☐ 0–2 days
    ☐ 3–14 days
    ☐ More than 15 days

11. Past Medical and Surgical History:

ILLNESSES	WHEN	COMMENTS
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, Convulsions, or Seizures		
k. Gallstones		
l. Gout		
m. Heart Attack/Angina		
n. Heart Failure		
o. Hepatitis		
p. High Blood Fats (cholesterol, triglycerides)		
q. High Blood Pressure (hypertension)		
r. Irritable Bowel		
s. Kidney Stones		
t. Mononucleosis		
u. Pneumonia		
v. Rheumatic Fever		
w. Sinusitis		
x. Sleep Apnea		
y. Stroke		
z. Thyroid Disease		
aa. Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
a. Back Injury		
b. Broken Bone (describe)		
c. Head Injury		
d. Neck Injury		
e. Other (describe)		
DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
a. Pap Smear		
b. Vaginal/Pelvic Ultrasound		
c. Mammogram		

d. Breast Ultrasound		
e. Breast MRI		
f. Breast Biopsy		
g. Cholesterol Check		
h. DEXA Bone Density		
i. Chest X-ray		
j. Colonoscopy		
k. Upper endoscopy		
l. Spine X-ray		
m. Neck X-ray		
n. NMR/MRI		
o. Skin Check		
p. EKG		
q. Abdominal Ultrasound		
OPERATIONS	**WHEN**	**COMMENTS**
a. Appendectomy		
b. Dental Surgery		
c. Gallbladder		
d. Hernia		
e. Hysterectomy (cervix/ovaries removed?)		
f. Tonsillectomy		
g. Other (describe)		
h. Other (describe)		

12. Hospitalizations:

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

13. How often have you have taken antibiotics?

	LESS THAN 5 TIMES	MORE THAN 5 TIMES
Infant/Child		
Teen		
Adult		

14. How often have you have taken oral steroids (e.g., cortisone, prednisone, etc.)?

	LESS THAN 5 TIMES	MORE THAN 5 TIMES
Infant/Child		

Teen		
Adult		

15. What medications are you taking now? Include nonprescription drugs (excluding supplements).

MEDICATION NAME	DATE STARTED	DOSAGE
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		

Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list: ____

____

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

VITAMIN/MINERAL/ SUPPLEMENT NAME	DATE STARTED	DOSAGE
a.		
b.		
c.		
d.		
e.		
f.		
g.		

17. Infancy/Childhood:

QUESTION	YES	NO	DON'T KNOW	COMMENT
a. Were you a full-term baby?				
A preemie?				
b. Were you breast-fed?				
Bottle-fed?				
c. As a child, did you eat a lot of sugar and/or candy?				

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): ___________________

____

____

18. Place a check mark next to each food/drink that is part of your current diet.

	USUAL BREAKFAST	√		USUAL LUNCH	√		USUAL DINNER	√
a.	No Breakfast		a.	No Lunch		a.	No Dinner	
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)	

19. 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	

20. Are you on a special diet? ☐ Yes ☐ No
    ☐ Vegetarian ☐ Vegetarian ☐ Other (describe below):
    ☐ Diabetic ☐ Blood type diet ______________________
    ☐ Dairy restricted ______________________

21. Is there anything special about your diet that we should know? ☐ Yes ☐ No
    If yes, please explain: ____
    ____

22. Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.?
    ☐ Yes ☐ No
    If yes, are these symptoms associated with any particular food or supplement(s)? ☐ Yes ☐ No
    If yes, please name the food or supplement and symptom(s) (Example: milk – gas and diarrhea):
    ____
    ____

23. Do you feel you have delayed 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

24. Do you feel much worse when you eat a lot of :
    ☐ High-fat foods
    ☐ High-protein foods
    ☐ High-carbohydrate foods (breads, pastas, potatoes)
    ☐ Other: ______________________
    ☐ Refined sugar (junk food)
    ☐ Fried foods
    ☐ 1 or 2 alcoholic drinks

25. Do you feel much better when you eat a lot of :
    ☐ High-fat foods
    ☐ High-protein foods
    ☐ High-carbohydrate foods (breads, pastas, potatoes)
    ☐ Other: ______________________
    ☐ Refined sugar (junk food)
    ☐ Fried foods
    ☐ 1 or 2 alcoholic drinks

26. Does skipping a meal greatly affect your symptoms? ☐ Yes ☐ No

27. 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)? ____
    ____

28. Do you have an aversion to certain foods? ☐ Yes ☐ No
    If yes, what foods? ____

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

a. Frequency	√	c. Color	√
More than 3x/day		Medium brown consistently	
1–3x/day		Very dark or black	
4–6x/week		Greenish	
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			

30. Intestinal gas:
    - ☐ Daily
    - ☐ Occasionally
    - ☐ Excessive
    - ☐ Present with pain
    - ☐ Foul smelling
    - ☐ Little odor

31. Have you ever consumed alcohol? ☐ Yes ☐ No
    If yes, how often do you now drink alcohol?
    - ☐ No longer drinking alcohol
    - ☐ Average 1–3 drinks/week
    - ☐ Average 4–6 drinks/week
    - ☐ Average 7–10 drinks/week
    - ☐ Average more than 10 drinks/week

    Have you ever had a problem with alcohol? ☐ Yes ☐ No
    If yes, please indicate time period (month/year): from ________ to ___________

32. Have you ever used recreational drugs? ☐ Yes ☐ No

33. Have you ever used tobacco? ☐ Yes ☐ No
    If yes, number of years as a nicotine user: _____ Amount per day: _____ Year quit: _____.
    What type of nicotine have you used? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐Patch/Gum

34. Are you exposed to secondhand smoke regularly? ☐ Yes ☐ No

35. Do you have mercury amalgam fillings? ☐ Yes ☐ No

36. Do you have any artificial joints or implants (i.e. contacts, dentures, heart values)? ☐ Yes ☐ No

37. Do you feel worse at certain times of the year? ☐ Yes ☐ No
    If yes, when? ☐ Spring ☐ Fall ☐ Summer ☐ Winter

38. 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

39. Do odors affect you? ☐ Yes ☐ No

40. 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					

41. Have you ever had psychotherapy or counseling? ☐ Yes ☐ No
☐ Currently ☐ Previously If previously, from ______ to _______
What kind? ____
Comments: ____

42. 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: ____

43. Hobbies and leisure activities: ____
____

44. Do you exercise regularly? ☐ Yes ☐ No
If so, how many times a week? ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times
When you exercise, how long is each session? ☐ Less than 15 minutes ☐ 16–30 minutes
☐ 31–45 minutes ☐ More than 45 minutes
What type of exercise is it?
☐ Jogging/walking ☐ Tennis
☐ Basketball ☐ Water sports
☐ Home aerobics ☐ Other: ______________________________

45. Have you had a blood transfusion? ____

46. Did you mother take DES? ☐ Yes ☐ No

47. Are you concerned about workplace exposure? ☐ Yes ☐ No

48. Are there high and/or increasing levels of stress in your life? Explain: ______________________________

49. Unfortunately, abuse and violence of all kinds (verbal, emotional, physical, and sexual) are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

a. Did you feel safe growing up?
☐ Yes ☐ No

b. Have you been involved in abusive relationships in your life?
☐ Yes ☐ No

c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
☐ Yes ☐ No

d. Do you currently feel safe in your home?
☐ Yes ☐ No

e. Do you feel safe, respected, and valued in your current relationship?
☐ Yes ☐ No

f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
☐ Yes ☐ No

g. Would you feel safer discussing any of these issues privately?
☐ Yes ☐ No

h. Have you experienced sexual harassment?
☐ Yes ☐ No

50. FAMILY HISTORY: For each member of your family, follow the gray or white line across the page and check the appropriate boxes.

(Note: Except for ***spouse*** *, family refers to* ***blood*** *or* ***natural*** *relatives.)* **PRINT NAMES BELOW**	***Good Health***	***Poor Health***	***Deceased***	**Write in age and cause of death. Include accidents and suicides.**	***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***	***Stomach or Duodenal Ulcer***
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):																			

Has anyone in your family experienced any of the following:

	Yes	No			Yes	No
ALS, MS			**Lung disease**			
Depression/Anxiety			**Neurological Problems**			
Eating Disorder			**Obesity**			
Gallstones			**Osteoporosis**			
Glaucoma			**Stroke**			
Kidney Stones						

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 ☐ Nonsupportive

52. Have you ever contracted a sexually transmitted infection?

	Current	Past
Human Papilloma Virus (HPV)	______	______
Chlamydia	______	______
Gonorrhea	______	______
Herpes Simplex Virus (HSV)	______	______
Syphilis	______	______
HIV	______	______
Hepatitis	______	______

Place a check mark by each symptom that occurs now ***or*** that has occurred in the past 6 months.

GENERAL	Mild	Mod-erate	Severe
Cold hands and feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
Hot flashes/Night Sweats			
HEAD, EYES & EARS			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
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			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches around eyes			
Muscle twitches in arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Blackout			
Depression			
Difficulty with: Concentrating			
Balance			
Thinking			
Judgment			
Speech			
Memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			

MOOD/NERVES (continued)	Mild	Mod-erate	Severe
Light-headedness			
Numbness			
Other phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
DIGESTION			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of lower abdomen			
Bloating of whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures with poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			

DIGESTION (continued)	Mild	Mod-erate	Severe
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
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			
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 (continued)	Mild	Mod-erate	Severe
Eczema			
Herpes (genital)			
Hives			
Jock itch			
Lackluster skin			
Moles with 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			

SKIN, DRYNESS	Mild	Mod-erate	Severe
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
LYMPH NODES			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
NAILS			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus (fingers)			
Fungus (toes)			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of fingernails			
Thickening of toenails			
White spots/lines			

RESPIRATORY	Mild	Mod-erate	Severe
Bad breath			
Bad odor in nose			
Cough (dry)			
Cough (productive)			
Hay fever (spring)			
Hay fever (summer)			
Hay fever (fall)			
Hay fever (change of season)			
Hoarseness			
Nasal stuffiness			
Nosebleeds			
Postnasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

URINARY	Mild	Mod-erate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
Frequency			
MALE REPRODUCTIVE			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			