Bruley Center

Medical Symptoms Questionnaire

Name _____ **Date** _____

Rate each of the following symptoms based upon your typical health profile for:
☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale
0 - *Never* or *almost never* have the symptom
1 - *Occasionally* have it, effect is *not severe*
2 - *Occasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	Total _____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	
		(does not include near or far-sightedness)	Total _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	Total _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	Total _____
MOUTH/THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	Total _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	Total _____
HEART	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	
	_____	Chest pain	Total _____

LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	Total _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	Total _____
JOINTS/MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	Total _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Compulsive eating	
	_____	Water retention	
	_____	Underweight	Total _____
ENERGY/ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	Total _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Poor concentration	
	_____	Poor physical coordination	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	Total _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	Total _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	
			Total _____

GRAND TOTAL *TOTAL* _____

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 also assist us to formulate a treatment plan.

First Name: _____Middle Name :_____Last Name:_____

Address: _____

City: _____ State: _____ ZIP: _____ Country: _____

Home Phone: (_____) _____-_____ Birth Date: _____/_____/_____ Age: _____

month/day/year

Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____ Place of Birth:_____

Fax: (_____) _____-_____ City or town & country if not US

Occupation: _____

Name of Spouse/Significant Other: _____

Names of Children and ages:_____ _____

_____

Referred by: _____ Height: ___′ ____ ″ Weight: _____ Sex: _____

Today's Date: _____

Rate your overall health: (Poor) 1……10 (Excellent)
Rate your overall diet: (Poor) 1……10 (Excellent)
Rate your overall stress: (Poor) 1……10 (Excellent)

1. Other providers seen? ____Yes ____No If Yes, Name, Specialty (i.e., MD, DC, Naturopath, Physical or Massage Therapist, Acupuncturist) _____

Date of Last Physical Exam: _____ Abnormal Findings? _____Yes _____No

Date of Last Dental Exam: _____ Abnormal Findings? _____Yes _____No

When was the last time you felt your very best (physically, emotionally, spiritually): Date: _____

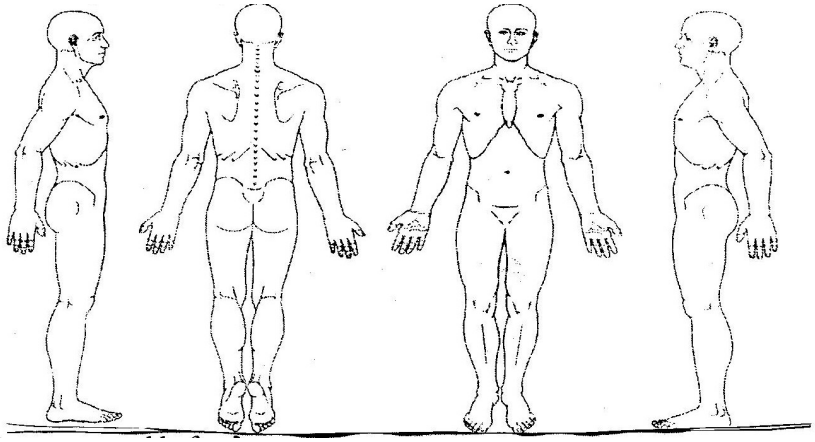
2 Please list up to 5 of your MAJOR health concerns, in order of importance:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			

How did symptoms begin? _____

Are you currently in pain? (No pain) 0_____10 (Worst pain)

Please mark any areas of pain on diagrams below



Have these problems occurred before? _____

Is your condition job-related or due to an accident? _____ Date: _____ Location:_____

Are your activities of daily life affected? _____

Do you suffer from any other condition for which you are not consulting with us? _____

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

4 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
If yes, type of animals, (name and age, if appropriate):_____ _____
_____

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

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

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

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. Previous jobs: _____
_____

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**
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag.	Barium Enema		

ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Urinalysis		
av.	Blood studies		
aw.	Last HIV		
az.	Other		

Please attach appropriate copies

	OPERATIONS	**WHEN**	**COMMENTS**
au.	Appendectomy		
av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

12 Hospitalizations:

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

13.How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

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

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

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

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
Use last page, if necessary		

16. Are you allergic to any medications? Yes____ No____
If yes, please list and reaction_____
_____
Are you latex sensitive? Yes____ No____
If not allergic, do you believe you are especially sensitive to any medications or substances?
Yes____ No____ If yes, please describe_____
More specifically, do any drugs make you sleepy or tired? Yes____ No____
If yes, please list_____
Do any drugs give you energy, make you anxious or cause insomnia? Yes____ No____
If yes, please list_____
Do any drugs just make you feel poorly? Yes____ No____
If yes, please describe_____
Have you had any reactions to medicines or substances that shouldn't have happened? Yes____ No____
If yes, please describe_____
How are you affected by alcohol? ___easily affected ___moderately affected ___ affected very little

17. Overall, how would you describe yourself with regard to medications?
___very sensitive ___not especially sensitive ___very tolerant, require high doses

18. Do you wear: shoe lifts_____ orthotics_____

19 .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.

Vitamin/Supplement/Mineral Name	Date Started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
Use last page, if necessary		

20. 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. Mother used drugs, medications, tobacco, alcohol during pregnancy?				
3. Induced Labor?				
4. Forceps/vacuum extraction/c-section?				
5. Do you remember you APGAR score? If yes, #				
6. Any complications of your delivery?				
7. Any particular health-related problems or accidents during the first year of life?				
8. As a child did you eat a lot of sugar and/or candy?				
9. Were you given vitamins or fluoride as a child?				
10.As a child, did you live in a home built before 1978?				
11.Were you screened for lead?				
12.Did you have: a) hyperactivity/attention deficit? b) learning or behavioral problems? c) frequent ear infections? d) allergies or asthma?				

e) any particular health-related problems, or accidents				

22. 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

23. 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)	

How many ½ cup servings of fruits and vegetables do you have in a typical day? _____

24. 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	
n.	Fast food	
o.	Processed food	
p.	Snack food Describe_____	

25. How much water do you drink each day? ____ (8 ounce glasses)

Tap__ Yes__ No__
Filtered__ Yes__ No__
Bottled__ Yes__ No__
Well__ Yes__ No__

Do you have a water filter? If so, what type?_____

26. Are you on a special diet? Yes____ No____

_____ ovo-lacto _____ vegetarian _____ other (describe):
_____ diabetic _____ vegan _____
_____ dairy restricted _____ blood type diet _____

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

28 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.

_____
_____

29. 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____

30. 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 _____

31. 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 _____

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

33. 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)? _____
_____
What are your favorite foods? _____

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

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

a. Frequency	√	b. Color	√
More than 5x/day			
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			

36. Intestinal gas: _____Daily _____ Present with pain
_____Occasionally _____ Foul smelling
_____Excessive _____ Little odor
37. a. Have you ever used alcohol? Yes____ No____
b. Type of alcohol ___wine ___beer ___spirits
c. 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
38. Have you ever used recreational drugs? Yes____ No____
39. Have you ever been in trouble (job, legal, family) because of your alcohol or drug use? Yes__ No__
40. Do you think that you have a problem with your alcohol/drug use? Yes___ No___
41. Do others think that you have a problem with your alcohol/drug use? Yes ___ No___
42. Have you ever felt that you should cut down on your drinking or drug use? Yes___ No___
43. Have you ever felt bad about your drinking or drug use? Yes___ No___
44. Have you ever had a drink or drug in the morning as an eye opener, to steady your nerves, or to get rid of a hangover? Yes___ No___

When using alcohol or drugs, have you ever had:

a) memory loss/blackout? Yes___ No___
b) DTs? Yes___ No___
c) seizures Yes___ No___
d) severe heartburn? Yes___ No___
e) hepatitis or other medical problem: Yes ___ No___

When was the last time you have vomited from alcohol or drug usage? _____ Never have __

45. Do you want to quit tobacco, alcohol, or drug usage? Yes___ No___
46. 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
Are you currently smoking? Yes____ No____
47. Are you exposed to second hand smoke regularly? Yes____ No____
48. Do you have mercury amalgam fillings? Yes____ No____
49. Do you have any artificial joints or implants? Yes____ No____
50. Do you feel worse at certain times of the year? Yes____ No____
If yes, when? _____spring _____fall
_____summer _____winter
51. 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

Have you had, at home or work in the past year, any new carpeting, painting, or construction? Yes__ No __
Do you have a home with an attached garage? Yes___ No___
Do you live or work in a structure that has been flooded in the past year? Yes___ No___
Has your home or workplace been chemically treated for pests in the past year? Yes___ No___
Has your lawn been treated chemically? Yes___ No___

52. Do odors affect you? Yes____ No____
Are you chemically sensitive? Yes___ No___

53. Blood Type _____Nationality/Ethnicity Background_____
    a. History of blood transfusions? _____

54. 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 With your family overall					
k. Financially					
l. Emotionally					
m. Coping with daily problems					
n. Do you feel safe at home?					

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

56. 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: _____
If not married, are you currently in a relationship? Yes____ No_____

57. Hobbies and leisure activities: _____
_____

58. 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 _____

Have you ever been injured as a result of your exercise? Yes____ No____

Sleep	Actual	Preferred
Time of rising	_____	_____
Time of retiring	_____	_____
Hours slept	_____	_____

59. Are you refreshed in the morning? Yes___ No___

Do you:

a) sleep walk or talk Yes___ No___
b) Have intense dreams Yes___ No___
c) Have hours-long, epic dreams Yes___ No___
d) Nightmares Yes___ No___
e) Grind your teeth Yes___ No___
f) Have restless legs Yes___ No___
g) Frequent night waking Yes___ No___
h) Have no dream recall Yes___ No___
i) Have problems getting to sleep Yes___ No___
If so, how long do you do think it takes you to fall asleep _____
j) Have problems staying asleep Yes___ No___
If so, what time do you typically wake up _____
k) Do you snore Yes___ No___
l) Stop breathing, snort or gasp for air during your sleep Yes___ No___
m) Jerk, twitch, or jump during sleep Yes___ No___
n) Feel sleepy during the day Yes___ No___
o) Fall asleep while watching TV, reading, etc. Yes___ No___

60. Vacation
    a. Week(s) per year _____
    b. Last vacation (date) _____
61. Work
    a. Hours per week ____
    b. Hours per shift ____
    c. Hours commuting per day ____
        i. Urban ____ Rural____

62. Life Enjoyment Rate 0 (least) to 10 (most)
    a. Time for things you enjoy ____
    b. Sense of happiness and joy ____
    c. Self-confidence ____
    d. Self-worth ____
    e. Feelings of being open to others ____
    f. Interest in maintaining a healthy lifestyle ____
    g. Romantic life ____
    h. Your ability to adapt to change ____
    i. Having life goals ____
    j. Accomplishing those goals ____
    k. Ability to forgive others and yourself ____
    l. Your life as a whole ____

63. With whom do you share your feelings? _____
    What give you joy in life?_____
    Who is the biggest source of your emotional support?_____
    Please describe briefly any parts of your body, and/or life, that you do not like_____
    _____

64. Nuclear exposure

__ I have lived – or currently live - near a nuclear plant

__ I lived, or was in the vicinity, of:

__ U.S. nuclear test sites in Nevada, during the 1950s and 1960s, or in states surrounding the sites, including Missouri, Colorado, Montana, Idaho and Utah.

__ the accident at Chernobyl on 4/26/86 (including the Ukraine, Belarus or the Russian Federation, in particular, as well as other countries at risk including Denmark, Finland, Poland, Austria, Germany, Greece, and Italy.)

__ French nuclear testing at Muroroa, in the Tuomotu islands, in French Polynesia (Tahiti)

__ the former nuclear weapons plant at Hanford in south-central Washington, especially between 1955 – 1965

__ Hiroshima or Nagasaki in 1945 or environs

__ US nuclear test sites at Bikini atoll in the Pacific

__ Cincinnati, Ohio, "Fernald Feed Processing Facility" 1952 – 1989

__ Concord, Massachusetts (depleted uranium contamination in ground water)

65. EMF Exposure

I live or work near any high power electrical wires or power transformers._____

I have electrical cords running under my bed._____

I use electric blankets._____

I travel frequently in commercial airliners._____

I sit by a computer for prolonged lengths of time._____

I use a cell phone_____ Amount (hours) per day_____

66. Additional environment

Do you do any regular welding, auto body work, painting, or commercial farming? ___

Did you ever work in an industry with known or suspected asbestos exposure? ____

Did you ever serve in the military?___

If yes, what service_____, where_____, when_____

Does the paint in your home contain lead? ____

Have you worked in a dental office? ____

Do you have mercury dental amalgams? ____

Did you have your mercury dental amalgam fillings removed? _____

If yes, when_____, how many____, nutritional therapies to aid detoxification? _____

Did you have any dental procedures prior to the onset of your symptoms? _____

How much fish/seafood do you eat and what type? _____

Is it possible that before your symptoms began, that you were exposed to mercury?_____

What type of household cleaners do you regularly use?_____ _____

_____

I use: air fresheners__ scented laundry detergents__scented fabric softeners__

Do you use a humidifier in the dry months?____

Do you cook with aluminum pots and pans? ____

Do you use artificial sweeteners?____

I generally purchase: organic foods____ non-organic foods____

Do you take acetaminophen (Tylenol) Yes___ No___

Can you think of any (other) possible toxic exposure?_____ _____

68.

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 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:																			
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):																			

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

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

FOR WOMEN ONLY (questions 71-79):

71. Have you ever been pregnant? (If no, skip to question 72.) Yes____ No____

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____

Have you had other problems with pregnancy? Yes____ No____

If so, please comment: _____
_____

72. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram_____
Pap Smear: ___ Normal ___Abnormal
Mammogram: ___ Normal ___ Abnormal
Date of last menstrual period_____
Was it normal yes____ no____ If the answer is no, how was it different _____
73. Have you ever used birth control pills? Yes____ No____ If yes, when _____

74. Are you taking the pill now? Yes____ No____

75. Did taking the pill agree with you? Yes____ No____ Not applicable _____

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

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

78. How long have you been on hormone replacement therapy (if applicable)? _____

79. In the second half of your cycle, do you have symptoms of breast tenderness,
water retention, or irritability (PMS)? Yes____ No____ Not applicable _____

80. Please check if these symptoms occur presently **or** have occurred in the past 6 months.

GENERAL:	Mild	Mod-erate	Severe
Allergies			
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Dieting often			
Difficulty falling asleep			
Early waking			
Excessive sweating			
Problems sweating at all			
Fatigue			
Fever			
Fluid retention			
Flushing			
Frequent illness			
Heat intolerance			
Wounds heal slowly			
Vaccine reactions			
HEAD, EYES & EARS:			
Bags or circles under eyes			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Glasses			
Hair loss			
Headache			
Morning headache			
Hearing loss			

Eyes, Head & Ears, cont.	Mild	Mod-erate	Severe
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	Mild	Mod-erate	Severe
Ankle pain			
Arm pain			
Back muscle spasm			
Calf cramps			
Chest tightness			
Chewing problems			
Chronic pain			
Double jointed			
Foot cramps			
Foot pain			
Hand pain			
Hip pain			
Jaw clicking			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness Knee Problems			
Leg pain			
Loss of height			
Low back pain			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck pain			

Musculoskeletal cont	Mild	Mod-erate	Severe
Neck muscle spasm			
One leg shorter than the other			
Pain between shoulder blades			
Paralysis			
Scoliosis			
Tendonitis			
Tension headache			
TMJ problems			
Unexplained fractures			
Walking difficulties			
MOOD/NERVES:			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black-out			
Cold hands and feet			
Confusion			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			

Mood and Nerves cont.	Mild	Mod-erate	Severe
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 breath			
Bad teeth			
Black stools			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Cramping			
Dental problems			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Excessive mucus (phlegm)			
Farting			
Fissures			
Foods "repeat" (reflux)			
Heartburn			

Digestion cont.	Mild	Mod-erate	Severe
Hemorrhoids			
Indigestion			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Loss of taste or smell			
Lower abdominal pain			
Mucus in stools			
Nausea			
Parasites			
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			
Cold sores/fever blisters			
Dark circles under eyes			
Ears get red			
Easy bruising			

SKIN PROBLEMS, Cont'd:	Mild	Mod-erate	Severe
Eczema			
Herpes – genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Outer 1/3 of eyebrow thinning			
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			
Thinning of pubic hair			
Vitiligo			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

SKIN, DRYNESS OF:	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			
Groin/armpit swelling			
NAILS:			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus – fingers			
Fungus – toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			
Toenails			
White spots/lines			

RESPIRATORY:	Mild	Mod-erate	Severe
Bad breath			
Bad odor in nose			
Bloody cough			
Cough – dry			
Cough – productive			
Hay fever : Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Anemia			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Low blood pressure			
Mitral valve prolapse			
Palpitations			
Pacemaker			
Phlebitis			
Prosthetic Valves			
Stroke			
Swollen ankles/feet			
TIAs			
Varicose Veins			

URINARY:	Mild	Mod-erate	Severe
Bed wetting			
Discolored urine			
Foul smelling urine			
Frequency			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
Sexual abuse history			
Sexually active			
Unprotected Sex			
FEMALE REPRODUCTIVE:			
Breast cysts			
Breast cancer			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Nipple discharge			

Female Reproductive continued	Mild	Mod-erate	Severe
Pain during sex			
Sexual abuse history			
Sexually active			
Unprotected sex			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			

Are you pregnant? Yes__ No__ Don't know___

FEMALE REPRODUCTIVE, Cont'd:	Mild	Mod-erate	Severe
Premenstrual: _____ Acne_____ Bloating			
Breast tenderness			
Carbohydrate/sweet craving			
Chocolate craving			
Confusion			
Constipation			
Decreased sleep			
Depression			
Diarrhea			
Dizziness or fainting			
Fatigue			
Forgetfulness			
Headache			
Heart pounding			
Increased appetite			
Increased sleep			
Irritability			
Mood swings			
Nervousness/Anxiety			
Oily skin			
Swelling of extremities			
Vaginal discharge			
Weight gain			
Other			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
Low back pain			
No periods			
Scanty periods			
Spotting between			
Vaginal discharge			
Post-Menstrual: Bleeding			
Vaginal Discharge			
Other			

81. Hysterectomy? Yes___ No___
If Yes, Full____ Partial____
If yes, were hormones given after surgery?
Yes___ No___ Which ones_____
How soon after surgery were they given to you?
_____

82. Did any of your major symptoms begin immediately, or soon after, a pregnancy? _____

This information is confidential, and will stay in your locked health file in this office, and will not be released without your express, written permission, within the confines of the law

Additional Information

