Some Patients Have Chemical Sensitivities. Please Do Not Wear Perfumes or Fragrant Products to the Office.

Date: ______________________________

Patient Name: ____

Date of Birth: ____________________________ Age: ____________ Sex: M F

Are you: Married Single Divorced Widowed Separated

How did you hear about our center? ____

When did you have your last health care visit? ____________________________________

What was the reason? ____

Please list, in order of importance, your health problems:

1. ____
2. ____
3. ____
4. ____
5. ____

Family History Y = yes N = no P = past

Has any family member had the following:				If yes, please identify family member:
Anemia	Y	N	P	______________________________
Asthma	Y	N	P	______________________________
Cancer	Y	N	P	______________________________
Diabetes	Y	N	P	______________________________
Epilepsy	Y	N	P	______________________________
Glaucoma	Y	N	P	______________________________
Heart Disease	Y	N	P	______________________________
High Blood Pressure	Y	N	P	______________________________
Kidney Disease	Y	N	P	______________________________
Mental Illness	Y	N	P	______________________________
Pneumonia	Y	N	P	______________________________
Stroke	Y	N	P	______________________________
Tuberculosis	Y	N	P	______________________________
Venereal Disease	Y	N	P	______________________________

Were any of these a cause of death? If so, which family member and at what age? __________
____

Immunizations

Polio	Y	N	Diphtheria	Y	N	Rubella	Y	N
Measles/Mumps	Y	N	Pertussis	Y	N	Hepatitis B	Y	N
Pneumonia	Y	N	Small Pox	Y	N	Anthrax	Y	N
Tetanus	Y	N	Date of last tetanus shot: ____________________					

Childhood Illnesses

Scarlet Fever Y N Diphtheria Y N Rheumatic Fever Y N Mumps Y N Measles Y N German Measles Y N **Allergies**

What are you allergic to? ____

What foods? ____

Environmental Allergies? ____

Have you ever been hospitalized? Y N If yes, when and for what reason? ___________

____

Have you had any surgeries? Y N If yes, when and for what reason? ___________

____

Current Medications

Appetite Suppressants	Y	N	Laxatives	Y	N
Tobacco	Y	N	Antacids	Y	N
Pain Relievers	Y	N	Tranquilizers	Y	N
Birth Control Pills	Y	N	Sleeping Pills	Y	N
Thyroid	Y	N	Cortisone	Y	N

Please list any prescription medications, over-the-counter medicines, vitamins or other supplements you are currently taking: ____

____

____

Environmental

Have you often had to lower the regular dose of prescription, over-the-counter medication or herbal supplements because you were too sensitive to normal doses? Y N P

Do you avoid caffeine in the afternoon or all together because it can keep you up at night? Y N P

Have you ever experienced adverse reactions to medications? If so, what happened?

____

Do you smell odors when others can't? What kind of odors?

____

Do you have a sudden onset of symptoms (headaches, skin rashes, nausea, fatigue, shortness of breath, etc.) on exposure to chemicals, mold, dust, pollens, or other environmental allergens? What symptoms?

____

Please list all the chemicals that you have adverse reactions to:

____

Skin

Acne	Y	N	P	Boils	Y	N	P
Color Changes	Y	N	P	Eczema	Y	N	P
Hives	Y	N	P	Itching	Y	N	P
Rash	Y	N	P	Moles	Y	N	P
Lumps	Y	N	P	Scaling	Y	N	P

Head

Hair loss	Y	N	P	Headaches	Y	N	P
Head Injury	Y	N	P	Skull fracture	Y	N	P

Eyes

Eye Pain	Y	N	P	Cataracts	Y	N	P
Double vision	Y	N	P	Dryness	Y	N	P
Vision aids	Y	N	P	Glaucoma	Y	N	P
Impaired vision	Y	N	P	Tearing	Y	N	P

Ears

Discharge	Y	N	P	Earaches	Y	N	P
Dizziness	Y	N	P	Impaired hearing	Y	N	P
Ringing	Y	N	P	Trauma to ear	Y	N	P

Nose & Sinuses

Frequent Colds	Y	N	P	Hay fever	Y	N	P
Nose Bleeds	Y	N	P	Sinus pain	Y	N	P
Stuffiness	Y	N	P	Persistent running	Y	N	P
Trauma	Y	N	P	Polyps	Y	N	P

Mouth & Throat

Bleeding gums	Y	N	P	Difficulty swallowing	Y	N	P
Cavities	Y	N	P	Frequent sore throat	Y	N	P
Hoarseness	Y	N	P	Sore tongue	Y	N	P
Ulcerations	Y	N	P	Difficulty speaking	Y	N	P

Neck

Goiter	Y	N	P	Lumps	Y	N	P
Pain or Stiffness	Y	N	P	Swollen Glands	Y	N	P
Trauma to Neck	Y	N	P	Thyroid Medication	Y	N	P

Respiratory

Asthma	Y	N	P	Bronchitis	Y	N	P
Cough	Y	N	P	Emphysema	Y	N	P
Pneumonia	Y	N	P	Difficulty Breathing	Y	N	P
Pleurisy	Y	N	P	Pain with Breathing	Y	N	P
Sputum	Y	N	P	Shortness of Breath	Y	N	P
Tuberculosis	Y	N	P	with lying down	Y	N	P
Wheezing	Y	N	P	with exertion	Y	N	P
Blood in Sputum	Y	N	P	at night	Y	N	P

Cardiovascular

Angina	Y	N	P	Chest Pain	Y	N	P
High blood pressure	Y	N	P	Dizziness	Y	N	P
Heart disease	Y	N	P	Murmur	Y	N	P
Palpitations/flutter	Y	N	P	Leg pain with walking	Y	N	P
Rheumatic fever	Y	N	P	Ankle swelling	Y	N	P

Gastrointestinal

Belching	Y	N	P	Blood in stool	Y	N	P
Change in appetite	Y	N	P	Change in thirst	Y	N	P
Gall bladder disease	Y	N	P	Heartburn	Y	N	P
Gas/Bloating	Y	N	P	Hemorrhoids	Y	N	P

Liver disease	Y	N	P	Jaundice/yellow skin	Y	N	P
Vomiting	Y	N	P	Bowel Movements:			
Ulcers	Y	N	P	How often? ____________________			
				Is this a change?	Y	N	

Urinary

Frequent infections	Y	N	P	Frequency at night	Y	N	P
Increased frequency	Y	N	P	Unable to hold urine	Y	N	P
Kidney stones	Y	N	P	Kidney Pain	Y	N	P
Pain with urination	Y	N	P	Urethral discharge	Y	N	P

Endocrine/Blood

Anemia	Y	N	P	Excessive thirst	Y	N	P
Easy to bleed/bruise	Y	N	P	Heat/cold intolerance	Y	N	P
Excessive hunger	Y	N	P	Low energy/fatigue	Y	N	P

Female Reproductive System

Age menses began: ________________				Birth Control	Y	N	P
Average number of days: ____________				what type? __________________________			
Length of cycle: ___________________				Number of pregnancies: _________________			
Are cycles regular?	Y	N	P	Number of live births: ____________________			
Do you have:				Number of miscarriages: _________________			
Painful menses	Y	N	P	Number of abortions: _____________________			
Pain with intercourse	Y	N	P	Difficulty conceiving	Y	N	P
Excessive flow	Y	N	P	Menopause symptoms	Y	N	P
PMS	Y	N	P	History of venereal disease	Y	N	P
Sexual difficulties	Y	N	P	Are you sexually active	Y	N	P

Breasts

Do you do self exams	Y	N	P	Nipple discharge	Y	N	P
Lumps	Y	N	P	Skin discoloration	Y	N	P
Breast Pain	Y	N	P				

Male Reproductive System

Hernia	Y	N	P	Are you sexually active	Y	N	P
Testicular pain	Y	N	P	Sexual difficulties	Y	N	P
Testicular masses	Y	N	P	Prostate disease/pain	Y	N	P
Discharges or sores	Y	N	P	Venereal disease	Y	N	P

Musculoskeletal

Joint pain/stiffness	Y	N	P	Broken bones	Y	N	P
Swelling of joints	Y	N	P	Muscle cramps	Y	N	P
Arthritis	Y	N	P	Weakness	Y	N	P

Peripheral Vascular

Cold hands/feet	Y	N	P	Varicose veins	Y	N	P
Deep leg pain	Y	N	P	Spider veins	Y	N	P
Numbness hands/feet	Y	N	P	Thrombophlebitis	Y	N	P

Neurological

Dizziness	Y	N	P	Numbness/tingling	Y	N	P
Fainting	Y	N	P	Memory loss	Y	N	P
Seizures	Y	N	P	Paralysis	Y	N	P

Mental/Emotional

Anxiety/nervousness	Y	N	P	Excessive fears	Y	N	P
Depression	Y	N	P	Mood swings	Y	N	P
Excessive anger	Y	N	P	Tension/stress	Y	N	P

Habits

Do you wake rested Y N P

Sleep Well Y N P

Average hours of sleep: ____________

Enjoy your work Y N P

Watch television Y N P

How many hours/day: ______________

Work at a computer Y N P

How many hours/day: ______________

Read Y N P

How many hours/day: ______________

Take vacations Y N P

Do you use:

Recreational drugs Y N P

Alcoholic beverages Y N P

What are your main hobbies and interests?

____

____

What forms of exercise do you get?

____

____

Exercise how often?

____

Have you been treated for:

alcohol dependence Y N P

drug dependence Y N P

Infants and Children

Does your child:

Sleep through the night	Y	N	P	Eat well	Y	N	P
Frequent sore throats	Y	N	P	Frequent earaches	Y	N	P
Constipation	Y	N	P	Diarrhea	Y	N	P
Hyperactive	Y	N	P	Colic	Y	N	P
Constant runny nose	Y	N	P	Lethargic	Y	N	P
Abnormal weight gain/loss	Y	N	P	Irritable	Y	N	P
Behavioral problems	Y	N	P	Skin rashes	Y	N	P
Reaction to vaccines	Y	N	P				