

## Medical Questionnaire



INTEGRATIVE FAMILY  
WELLNESS CENTER

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_ **Sex** M F **DOB** \_\_\_\_\_ **Age** \_\_\_\_\_

**Blood Type** \_\_\_\_\_ **Occupation** \_\_\_\_\_ **Last school grade completed** \_\_\_\_\_

**Health Concerns.** Please list in order of importance. Rate severity (1 is low severity, 10 is high) and success (1 is no success, 10 is very successful).

Concern	Severity (1-10)	Past/Present Treatments	Success Level (1-10)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Are you currently under the care of a physician? Yes No Specialty?

If yes, with whom? What condition?

If no, when did you last receive medical care?

When was your last physical exam? Prostate Exam:

Date of last Pap: Pelvic:

Do you have a known infectious disease at this time? Yes No

If yes, what?

### Medications/Supplements

Please list all medications and vitamins/supplements you are currently taking in the following table:

*Current*

Name	Strength	Dosage	Reason	Duration
How much Calcium do you supplement daily?			Form?	
How much Magnesium do you supplement daily?			Form?	

*Past (Within last six months, circle any that apply)*

Pain Relievers Blood pressure Sleeping

Antacids Hormones Steroids (cortisone, predisone)

Antibiotics Insulin Thyroid

Appetite suppressants Laxatives Tranquilizers

Birth control Sedatives Supplements:

How often have you taken antibiotics? Childhood? Adulthood?

### Social History

With whom do you live? Pets? Indoor or outdoor? Farm animals?

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

## Medical Questionnaire



Typical Breakfast		Time
Lunch		Time
Dinner		Time
Snacks		

Food	Servings per Week	Food	Servings per Week
Beef		Fresh Fruit	
Poultry      Light		Fresh Vegetables	
Dark		Breads, cereals, grains, pasta	
Lamb		Legumes	
Fish		Seeds	
Pork		Nuts/Nut Butters	
Tofu/Soy Products		Butter (sticks/week)	
Eggs (#/week)		Oils:	
Yogurt              %fat			
Protein Powder (type)			
Cottage Cheese      %fat		Sweets (cookies, cakes, candy)	
Cheese (oz servings)			

Cravings? \_\_\_\_\_

Dietary restrictions or food aversions? \_\_\_\_\_

Time in between meals? \_\_\_\_\_

Main sources of protein? \_\_\_\_\_

Water intake:                      8 oz. glasses/day

Do you purchase organic fruits and vegetables?      Yes      No      Some

Do you purchase organic meat and dairy?              Yes      No      Some

Beverages (specify type)

	Yes	No	Past	Quantity/Week
Alcohol:				
Coffee/Tea:				
Soda:    Diet              Regular				
Milk:                      %fat				
Soy milk?				

Total pounds lost throughout your life dieting: \_\_\_\_\_

Do you use tobacco?    Yes    No    Past              Quantity: \_\_\_\_\_

Do you use recreational drugs?    Yes    No    Type: \_\_\_\_\_              Quantity: \_\_\_\_\_

Do you exercise?    Yes    No    What kind? \_\_\_\_\_              Frequency?              Duration?

Interests and hobbies: \_\_\_\_\_

Do you watch television?      Yes      No      Hours/Night? \_\_\_\_\_

Describe your work: \_\_\_\_\_

Do you take vacations?    Yes      No      Week (s) off/year: \_\_\_\_\_

Do you have a supportive relationship?    Yes      No      Married/Divorced/Single/Separated/Widowed

How important is spirituality or religion in your life? \_\_\_\_\_

## Medical Questionnaire



Sleep:

Hours/night	Yes	No	Past	Comments
Wake refreshed?				
Fall asleep easily (within 5 minutes)?				
Wake to urinate?				
Wake at other time:				
Do you snore?				
Do you stop breathing during sleep?				

Energy (scale of 1-10, 10 is the best) \_\_\_\_\_

Stress (scale of 1-10, 10 is most severe) \_\_\_\_\_

### Family History

	Age if Living	Age of Death	Health Problems (please list any cancers, cardiovascular disease, diabetes, thyroid or osteoporosis)
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Spouse			
Children			Birth weight:
			Birth weight:
			Birth weight:
			Birth weight:

### Personal History

Childhood illnesses	Yes, Had Disease	No, Never Had	Vaccinated
Scarlet Fever			
Mumps			
Diphtheria			
Rheumatic Fever			
German Measles			
Measles			

Childhood illnesses	Yes, Had Disease	No, Never Had	Vaccinated
Chicken Pox			
Shingles			
Smallpox			
Rubella			
Pertussis			
Other			

Other Vaccinations (circle)      Polio      Tetanus      Flu

Hepatitis B      Meningitis      HPV

Vaccination reactions? \_\_\_\_\_

## Medical Questionnaire



### Surgeries, Hospitalizations and Procedures

Surgery	Year	Reason
Appendectomy		
Tonsillectomy		
Dental		
Gallbladder		
Hernia		
Other		
Do you have any artificial joints or other implants?    Yes    No    Type?		
Hospitalizations	Year	Reason
Diagnostic Procedures	Year	Reason
Colonoscopy		
Mammography		
Ultrasound		
X-Ray		
DEXA (Bone Scan)		
CT/MRI		Location?

### Allergies

	Type	Reaction
Medications		
Foods		
Environmental		

### Environmental History

Please indicate (X) if you have any current or past exposure to the items listed in the following table:

Household	Current	Past	Reaction
Leaded paint			
Near refinery or industrial area			
New Carpet/Paint/Other Remodeling			
Pesticide/Insecticide Use			
Dry Cleaning			
Live in a Smoking Home			
Work			
Solvent Exposure			
Heavy Metals			
Fumes			
Chemicals			
Work in Smoking Environment			

Household	Current	Past	Reaction
Sensitivities			
Perfumes			
Detergents			
Gas or other Vapors			
Other			
Radiation			
Infectious			
Do you have metal or mercury fillings?    Yes    No			
Number?			
Done after 1976?    Yes    No			
Date of last filling:			
How many removed?			
Root canals currently?			
Root canals removed?			

## Review of Systems



Please **CIRCLE** from the following options:

Yes (Y)= A condition you have **now** or in the **past 6 months**, No (N)=never had, Past (P)= A condition you had in the past (**longer than 6 months ago**)

Cold Hands and Feet	Y	N	P
Daytime Sleepiness	Y	N	P
Early Waking	Y	N	P
Sleepwalking	Y	N	P
Nightmares	Y	N	P
No Dream Recall	Y	N	P
Snoring	Y	N	P
Chronic Infection	Y	N	P
Slow Wound Healing	Y	N	P
Chemical/Metal/Drug Poisoning	Y	N	P
Hyper/Hypo (circle) Thyroid	Y	N	P
Hot/Cold (circle) Intolerance	Y	N	P
Night Sweats	Y	N	P
Hyper/Hypo (circle)glycemia	Y	N	P
Diabetes	Y	N	P
Excess Thirst	Y	N	P
Excess Hunger	Y	N	P
Agoraphobia	Y	N	P
Auditory/Visual (circle) Hallucinations	Y	N	P
Treatment for Emotional Problem	Y	N	P
Considered/Attempted (circle) Suicide	Y	N	P
Panic Attacks	Y	N	P
Fearfulness	Y	N	P
Irritability	Y	N	P
Phobias	Y	N	P
Paranoia	Y	N	P
Seizures	Y	N	P
Muscle Weakness	Y	N	P
Loss of Memory	Y	N	P
Fainting	Y	N	P
Loss of Consciousness	Y	N	P
Nerve Pain	Y	N	P
Rash	Y	N	P
Eczema	Y	N	P
Hives	Y	N	P
Acne	Y	N	P
Boils	Y	N	P
Itching	Y	N	P
Skin Color Change	Y	N	P
Perpetual Hair Loss	Y	N	P
Head Lumps	Y	N	P
Athletes Foot	Y	N	P
Cellulite	Y	N	P

Dark Circles Under Eyes	Y	N	P
Ears/Face (circle) Red	Y	N	P
Moles with Color or Size Change	Y	N	P
Oily Skin	Y	N	P
Pale Skin	Y	N	P
Psoriasis	Y	N	P
Sensitive to Bites	Y	N	P
Shingles	Y	N	P
Skin Cancer	Y	N	P
Skin Darkening	Y	N	P
Strong Body Odor	Y	N	P
Thick Calluses	Y	N	P
Vitiligo	Y	N	P
Nails Bitten	Y	N	P
Brittle	Y	N	P
Curve Up	Y	N	P
Frayed	Y	N	P
Fungus	Y	N	P
Pitting	Y	N	P
Ragged Cuticles	Y	N	P
Ridges	Y	N	P
Thickening	Y	N	P
Toenail Problems	Y	N	P
White Spots/Lines	Y	N	P
Headache	Y	N	P
Migraine	Y	N	P
Tension Headache	Y	N	P
Head Injury	Y	N	P
Concussion	Y	N	P
Jaw/TMJ Problems	Y	N	P
Eye    Conjunctivitis	Y	N	P
Crusting	Y	N	P
Impaired Vision	Y	N	P
Eye Pain/Strain	Y	N	P
Glasses/Contacts	Y	N	P
Tearing or Dryness	Y	N	P
Double Vision	Y	N	P
Glaucoma	Y	N	P
Cataracts	Y	N	P
Eyelid Redness	Y	N	P
Muscle Twitch in Eye	Y	N	P
Impaired Hearing	Y	N	P
Earaches	Y	N	P
Dizziness	Y	N	P
Ear Fullness	Y	N	P
Other Ear Pain	Y	N	P

Sensitivity to Loud Noise	Y	N	P
Excess Saliva	Y	N	P
Dry Mouth	Y	N	P
Teeth Grinding	Y	N	P
Gum Problems	Y	N	P
Hoarseness	Y	N	P
Sore Tongue	Y	N	P
Coating on Tongue	Y	N	P
Loss of Taste	Y	N	P
TMJ Problems	Y	N	P
Teeth Problems	Y	N	P
Bleeding Gums	Y	N	P
Canker Sores	Y	N	P
Cold Sores	Y	N	P
Cracking at Corner of Lips	Y	N	P
Dentures	Y	N	P
Periodontal Diseases	Y	N	P
Neck Lumps	Y	N	P
Swollen Glands	Y	N	P
Goiter/Enlarged Thyroid	Y	N	P
Nose Stuffiness	Y	N	P
Sinus Fullness	Y	N	P
Nose Bleeds	Y	N	P
Loss of Smell	Y	N	P
Sinus Infection	Y	N	P
Postnasal Drip	Y	N	P
Bad Breath	Y	N	P
Sore throat	Y	N	P
Odor in Nose	Y	N	P
Dry/Productive (circle) Cough	Y	N	P
Sputum	Y	N	P
Spitting up Blood	Y	N	P
Wheezing	Y	N	P
Asthma	Y	N	P
Allergies	Y	N	P
Bronchitis	Y	N	P
Pneumonia	Y	N	P
Pleurisy	Y	N	P
Emphysema	Y	N	P
Pain on Breathing	Y	N	P
Shortness of Breath	Y	N	P
Positive TB Test	Y	N	P
Heart Disease	Y	N	P
Angina	Y	N	P
High Blood Pressure	Y	N	P
Low Blood Pressure	Y	N	P

Review of Systems



Irregular Pulse	Y	N	P
Blood Clots	Y	N	P
Phlebitis	Y	N	P
Rheumatic Fever	Y	N	P
Swelling in Knees/ Ankles/Feet (circle)	Y	N	P
Stroke	Y	N	P
Easy Bleeding/Bruising	Y	N	P
Anemia	Y	N	P
Deep Leg Pain	Y	N	P
Varicose Veins	Y	N	P
Thrombophlebitis	Y	N	P
Anal Spasm	Y	N	P
Anal Fissures	Y	N	P
Trouble Swallowing	Y	N	P
Dry Mouth	Y	N	P
Heartburn	Y	N	P
Change in Thirst	Y	N	P
Change in Appetite	Y	N	P
Nausea	Y	N	P
Vomiting	Y	N	P
Blood in Stool	Y	N	P
Mucus in Stool	Y	N	P
Black Stools	Y	N	P
Pain or Cramps	Y	N	P
Gallbladder Disease	Y	N	P
Belching	Y	N	P
Gas	Y	N	P
Bloating	Y	N	P
Ulcer	Y	N	P
Jaundice (yellow skin)	Y	N	P
Hemorrhoids	Y	N	P
Liver Disease	Y	N	P

Food Intolerance			
Lactose	Y	N	P
Gluten	Y	N	P
Corn	Y	N	P
Eggs	Y	N	P
Fatty Food	Y	N	P
Yeast	Y	N	P
Pain on Urination	Y	N	P
Burning on Urination	Y	N	P
Increased Frequency	Y	N	P
Increased Urgency	Y	N	P
Frequent Urination at Night	Y	N	P
Incontinence	Y	N	P
Bedwetting	Y	N	P
Hesitancy	Y	N	P
Frequent Infection	Y	N	P
Kidney Disease	Y	N	P
Kidney Stones	Y	N	P
Blood in Urine	Y	N	P
Bladder Pressure	Y	N	P
Urine Odor	Y	N	P
Urethra Pain	Y	N	P
Irritation	Y	N	P
Itching	Y	N	P
Sexually Transmitted Disease	Y	N	P
<b>MALE</b>			
Urination Difficulty	Y	N	P
Diagnosed with prostate issue or elevated PSA	Y	N	P
Swelling or lumps on testicles	Y	N	P
Testicular Pain	Y	N	P
<b>FEMALE</b>			

Age at Menarche:			
Date of last menses:			
Abnormal Vaginal Discharge	Y	N	P
Vaginal Odor	Y	N	P
Vaginal Itching	Y	N	P
Vaginal Pain	Y	N	P
Endometriosis	Y	N	P
Fibroids	Y	N	P
Ovarian Cysts	Y	N	P
Sexually Active	Y	N	P
Pain During Intercourse	Y	N	P
Regular Cycles	Y	N	P
Bleeding Between Cycles	Y	N	P
Painful Menses	Y	N	P
Clots	Y	N	P
Abnormal Pap	Y	N	P
Number of Pregnancies			
Number of Miscarriages			
Number of Abortions			
Difficulty Conceiving	Y	N	P
Breast Lumps	Y	N	P
Breast Cysts	Y	N	P
Muscle Spasm	Y	N	P
Joint Deformity	Y	N	P
Joint Redness	Y	N	P
Arthritis	Y	N	P
Broken Bones	Y	N	P
Muscle Weakness	Y	N	P
Back Pain	Y	N	P
Tendonitis	Y	N	P

Additional Concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Review of Systems



### Section 1:

Score the symptoms on the following scale:  
None-0, Mild-1, Moderate-2, Severe-3

1. Unexplained fevers, sweats, chills, or flushing: \_\_\_\_\_
2. Unexplained weight change; loss or gain: \_\_\_\_\_
3. **Fatigue, tiredness:** \_\_\_\_\_
4. Unexplained hair loss: \_\_\_\_\_
5. Swollen glands: \_\_\_\_\_
6. Sore throat: \_\_\_\_\_
7. Testicular or pelvic pain: \_\_\_\_\_
8. Unexplained menstrual irregularity: \_\_\_\_\_
9. Unexplained breast milk production; breast pain: \_\_\_\_\_
10. Irritable bladder or bladder dysfunction: \_\_\_\_\_
11. Sexual dysfunction or loss of libido: \_\_\_\_\_
12. Upset stomach: \_\_\_\_\_
13. Change in bowel function-constipation or diarrhea: \_\_\_\_\_
14. Chest pain or rib soreness: \_\_\_\_\_
15. Shortness of breath or cough: \_\_\_\_\_
16. Heart palpitations, pulse skips, heart block: \_\_\_\_\_
17. History of a heart murmur or valve prolapsed: \_\_\_\_\_
18. **Joint pain or swelling:** \_\_\_\_\_
19. Stiffness of the neck or back: \_\_\_\_\_
20. Muscle pain or cramps: \_\_\_\_\_
21. Twitching of the face or other muscles: \_\_\_\_\_
22. Headaches: \_\_\_\_\_
23. Neck cracks or neck stiffness: \_\_\_\_\_
24. **Tingling, numbness, burning, or stabbing sensations:** \_\_\_\_\_
25. Facial paralysis (Bell's palsy): \_\_\_\_\_
26. Eyes/vision-double, blurry: \_\_\_\_\_
27. Ears/hearing-buzzing, ringing, ear pain: \_\_\_\_\_
28. Increased motion sickness, vertigo: \_\_\_\_\_
29. Light-headedness, poor balance, difficulty walking: \_\_\_\_\_
30. Tremors: \_\_\_\_\_
31. Confusion, difficulty thinking: \_\_\_\_\_
32. Difficulty with concentration or reading: \_\_\_\_\_
33. **Forgetfulness, poor short-term memory:** \_\_\_\_\_
34. Disorientation, getting lost, going to wrong places: \_\_\_\_\_
35. Difficulty with speech or writing: \_\_\_\_\_
36. Mood swings, irritability, depression: \_\_\_\_\_
37. **Disturbed sleep, too much, too little, early awakening:** \_\_\_\_\_
38. Exaggerated symptoms or worse hangover from alcohol: \_\_\_\_\_

**TOTAL:** \_\_\_\_\_

If you rated a 3 for symptom numbers 3, 33, 18, 24, or 37 in section 1, add 5 additional points:

**TOTAL:** \_\_\_\_\_

### Section 2:

Circle the points for each of the statements you can agree with:

1. You have had a tick bite with no rash or flu-like symptoms-3
2. You have had a tick bite with a rash and flu-like symptoms-5
3. You live in a Lyme endemic area-2
4. You have a family member who has been diagnosed with Lyme disease-1
5. You experience migratory muscle pain-4
6. You experience migratory joint pain-4
7. You experience tingling, burning, numbness that migrates and comes and goes-4
8. You have received a prior diagnosis of chronic fatigue syndrome or fibromyalgia-3
9. You have received a prior diagnosis of a specific autoimmune disorder such as Lupus, MS, RA, or of a nonspecific autoimmune disorder-3
10. You have had a positive Lyme test-5

**TOTAL:** \_\_\_\_\_

### Section 3:

Regarding your overall health, for how many days was your physical health not good? \_\_\_\_\_

0-5 days: 1 point

6-12 days: 2 points

13-20 days: 3 points

21-30 days: 4 points

**TOTAL:** \_\_\_\_\_

Regarding your overall mental health, for how many days was your mental health not good? \_\_\_\_\_

0-5 days: 1 point

6-12 days: 2 points

13-20 days: 3 points

21-30 days: 4 points

**TOTAL:** \_\_\_\_\_

**COMBINED FINAL TOTAL:** \_\_\_\_\_

**46 or more=High probability**

**21-45=Possibility**

**21 or below=Not likely**