Medical Questionnaire

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?

Integrative Family Wellness Center 16535 W Bluemound Rd. Suite 222, Brookfield WI 53005 Phone: 262-754-4910

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				
Soymilk?				

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?

Integrative Family Wellness Center 16535 W Bluemound Rd. Suite 222, Brookfield WI 53005 Phone: 262-754-4910

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			
Diptheria			
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? ____

Integrative Family Wellness Center 16535 W Bluemound Rd. Suite 222, Brookfield WI 53005 Phone: 262-754-4910

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?			

Integrative Family Wellness Center 16535 W Bluemound Rd. Suite 222, Brookfield WI 53005 Phone: 262-754-4910

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**)

Condition			
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

Condition			
Dark Circles Under Eyes	Y	N	P
Ears/Face (circle) Red	Y	N	P
Moles with Color or Size Shange	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

Condition			
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

Integrative Family Wellness Center 16535 W. Bluemound Rd. Suite 222, Brookfield WI 53005 Phone: 262-754-4910

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
MALE	
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
FEMALE	

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:____

Integrative Family Wellness Center 16535 W. Bluemound Rd. Suite 222, Brookfield WI 53005 Phone: 262-754-4910

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

Integrative Family Wellness Center 16535 W. Bluemound Rd. Suite 222, Brookfield WI 53005 Phone: 262-754-4910