Center for Optimum Health, P.C.

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Dear Patient:

Please fill out this extensive questionnaire and bring it with you for your appointment on _____ at _____. It has been designed to provide a complete evaluation of your health and lifestyle. Please plan on taking up to one to two hours to properly fill in all the information. Some of the questions may deal with very personal information. You do not have to provide any information that you do not want to, however it is frequently the most sensitive areas of life that can be the most important with respect to health. Please be as candid as possible. These records are kept confidential from all sources including spouses and parents. Also note you may require some help on the questions that deal with early childhood. Please try to be as thorough as possible.

As some of our patients are chemically sensitive, we ask that you please not wear perfume, cologne, or scented hairspray at the time of your appointment. You may wish to bring socks or slippers to wear in the office. We request the courtesy of at least 48 hours cancellation notice prior to your visit or you may be charged for a missed appointment.

Name_____Marital Status_____Date_____/_____/_____

How did you hear of us?_____

Dates of last: Complete physical exam_____, Blood Test_____

Mammogram _____, Pap Test _____, Rectal Exam _____

List any other doctors you are currently consulting:

Name _____Address_____ Phone_____

_____

_____

_____

Height_____ Weight _____ Age _____ Last time you really felt well_____

Please list, in order of importance, the symptoms concerning you most.

Symptom_____ How long_____ How often_____ How severe_____

_____

_____

_____

_____

_____

Past history- On the back side of this sheet, please list in chronological order any illnesses, hospitalizations, injuries, pregnancies, abortions, miscarriages, surgeries, dental fillings, root canals, immunizations, and other medical or diagnostic procedures such as x-rays or biopsies. Minor problems such as flus and colds are not a concern, but please try to be as complete as possible.

List any allergies or sensitivities to drugs, supplements, herbs, foods, pollen, animals, or chemicals.

_____

_____

_____

_____

List all medications you are currently taking. Include birth control pills and non-prescription drugs.

Name_____ Reason _____ How long_____ How often_____

_____

_____

_____

_____

_____

Have you ever had a frequent or prolonged use of the following drugs? If so, how old were you at the time and how long did you take them?

Antibiotics_____ Antihistamines _____

Cortisone, ACTH, Prednisone _____ Steroids _____

Please describe how you feel about your relationships, etc. Use an "S" for satisfying, "OK" if fine, and "P" if it might be a problem area.

Spouse _____ Children _____ Work _____ Sex life _____ Finances _____ Your life in general _____.

Briefly describe any problem area on the reverse side of this sheet.

Do you smoke or have you smoked? _____ How much? _____ __ How long?_____

Have you stopped? _____ If so, when? _____ Would you like to stop? _____

Alcohol intake (type, amount, frequency)_____

Have you ever had a problem with alcohol or drugs?_____

Do you have any Tattoos? _____ How many?_____ Locations_____

Do you have any Body Piercings?_____ How many? _____Locations_____

Do you exercise regularly? _____ Type of exercise _____

How often_____ Length of sessions _____

Would you describe your stress level as low, moderate, or high? _____

Describe the kind of work you do? _____

Does your place of work have: Smoking ____, Toxic fumes ____, Fresh air ____, Florescent Lights ____, New paint_____ New carpets _____, Window providing light _____, New Building _____, Radiation ____, Chemicals ____ , ?

Do you use a computer at your desk or work station? _____

Have you ever lived or worked around paints, pesticides, chemicals, radiation, mercury, lead, asbestos, or heavymetals? _____

Have you ever lived in a trailer? _____ When _____ How long?_____

Are there any personal problems or feelings that you don't feel quite comfortable discussing with your closest friends? _____ Would you like to discuss them with the doctor? _____

Please check if any of the following apply to you. Use '**P**' if they applied in the past, '**C**' if they are current, and '**I**' if they are intermittent.

_____ Headaches
_____ Neck pain
_____ Neck lumps/ swelling
_____ Loss of balance
_____ Dizzy spells/ vertigo
_____ Fainting/ lightheadedness
_____ Blurry vision/ double vision
_____ Cataracts
_____ Glaucoma
_____ Eye pain or itching
_____ Watering eyes
_____ Mental confusion/ cloudiness
_____ Hearing difficulties
_____ Earaches or drainage
_____ Noises or ringing in the ear
_____ Recurrent ear infections
_____ Dental problems/ decay
_____ Sore or bleeding gums
_____ Sore tongue
_____ Decreased sense of taste
_____ Sores in or around mouth
_____ Difficulty swallowing
_____ Herpes or cold sores
_____ Congested or runny nose
_____ Sneezing spells
_____ Frequent colds or infections
_____ Nasal polyps
_____ Sore throats
_____ Hoarse voice
_____ Hepatitis, pancreatitis
_____ Colitis or Crohn's disease
_____ Diverticulosis or diverticulitis
_____ Waking from sleep to urinate
_____ Frequent urination
_____ Involuntary loss of urine
_____ Burning on urination
_____ Brown, red, or cloudy urine
_____ Decreased force of urine stream
_____ Difficulty starting urination
_____ Continual urge to urinate
_____ Kidney stone
_____ Bladder or kidney infections
_____ Venereal disease
_____ Hernia
_____ Osteoporosis
_____ Pain in muscles or joints
_____ Arthritis/ Bursitis
_____ Back or shoulder pain
_____ Weakness
_____ Painful feet
_____ Leg cramps
_____Trembling or tremors
_____ Seizures or epilepsy

_____ Anemia
_____ Hair loss
_____ Numbness or tingling
_____ Acne
_____ Skin tumors
_____ Sinusitis
_____ Shortness of breath
_____ Wheezing or asthma
_____ Cough
_____ Cough up blood
_____ Chest colds/ pneumonia
_____ Heart murmur
_____ High blood pressure
_____ Rapid or skipped heartbeat
_____ Chest pain, chest pressure
_____ Swollen feet or ankles
_____ Varicose or spider veins
_____ Difficulty breathing at night
_____ Phlebitis/ embolism
_____ Stomach or duodenal ulcers
_____ Indigestion or heartburn
_____ Nausea or vomiting
_____ Intestinal gas
_____ Bloating
_____ Belching
_____ Flatulence
_____ Abdominal pain or cramps
_____ Constipation
_____ Diarrhea or loose stools
_____ Black stools
_____ Gray stools
_____ Jaundice
_____ Pain in rectum
_____ Rheumatic fever
_____ Stroke
_____ Blood in stools
_____ Dry skin, irritation, flaking
_____ Rash, excema, psoriasis
_____ Hives
_____ Scalp problems, dandruff
_____ Bruise easily
_____ Thyroid disturbance/ goiter
_____ Loss or gain in weight
_____ Itching or burning skin
_____ Feel warm
_____ Feel cold
_____ Loss of appetite
_____ Always hungry
_____ Armpit or groin swelling
_____ Fatigue or weariness
_____ Sleep difficulty
_____ Fever
_____ Chills

_____ Excessive sweating
_____ Inability to perspire
_____ Night Sweats
_____ Diabetes/ low blood sugar
_____ Lowered sex drive
_____ Nervousness/ anxiety
_____ Depression
_____ Received blood or plasma
_____ Cancer or tumors
_____ Elevated cholesterol
_____ Suicidal thoughts
_____ Hyperactivity
_____ Gout
_____ Gallstones
_____ Traveler's diarrhea/ tourista
_____ Rectal itching
_____ Brittle fingernails
_____ Heart disease
_____ Neurological disease
_____ Reaction to immunization

How often do your bowels move? _____

For men only:
_____ Lump or swelling of testicle
_____ Difficulty with erection
_____Drainage from penis
_____ Prostate problems

For women only:
_____ Irregular menstrual period
_____ Premenstrual symptoms
_____ Vaginal discharge
_____ Painful intercourse
_____ I.U.D.
_____ Discharge from nipples
_____ Spotting between periods
_____ Menstrual cramps
_____ Vaginal rash/ itching
_____ Pelvic infection
_____ Breast lumps or pain
_____ Hot flashes

Date of last menses _____ How many days between menstrual periods? _____

Have any of your immediate family (including grandparents) had:
_____ Alcohol or drug problems
_____ Thyroid problems
_____ Cancer
_____ Diabetes
_____ Tuberculosis
_____ Mental illness
_____ Anemia
_____Gout
_____ Weight disorder
_____ Heart disease
_____ High blood pressure
_____ Osteoporosis

Family history (please list age or age at death, and any medical problems):
Father_____
Mother _____
Grandmother _____
Grandmother _____
Grandfather _____
Grandfather _____
Brothers _____
Sisters_____

Please estimate about how often you eat the following foods:
VERY FREQUENT = Once or more per day **OFTEN** = 3 or 4 times per week
OCCASIONAL = Once per week **SELDOM** = One or two times per month
NEVER = Essentially total avoidance

1. Fresh fruit _____
2. Fresh vegetables _____
3. Whole grains _____
4. Organic grains _____
5. Legumes (beans) _____
6. Butter _____
7. Eggs _____
8. Meats(poultry,fish) _____
9. Sugar, desserts _____
10. Pkgd./proc. Food _____
11. Chips _____
12. Frozen/can food _____

13. Coffee _____
14. Black tea _____
15. Alcohol _____
16. Restaurants _____
17. Fast food restaurants_____
18. Sodas _____
19. Fried foods _____
20. Mayo/margarine _____
21. Milk _____
22. Cheese _____
23. Salt _____
24. White flour product_____
25. Excessive eating _____

Specify what foods and drinks you normally take during a day:

Morning _____

Afternoon _____

Evening _____

Do you think you might have an eating disorder? _____

How often during the day do you eat something? _____

Do you completely chew your foods before swallowing? _____

What water do you drink? _____ Do you have a water purifier? _____

If so, what kind? _____

Do you use an: electric blanket _____, electric mattress pad _____, water bed _____, or microwave _____?

List history of foreign travel: U.S.A.

(East) _____ When? _____

(West) _____ When? _____

(South) _____ When? _____

(Central) _____ When? _____

Foreign _____ When? _____

_____ When? _____

_____ When? _____

_____ When? _____