

## 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: _____	
Home Phone: (____) _____ - _____	Birth Date: ____/____/____ Age: _____ month    day    year
Work Phone: (____) _____ - _____	Place of Birth: _____
Occupation: _____	City or town & country if not US
Referred by: _____	Height: ____' ____" Weight: _____ Sex: _____
Today's Date _____	

1. Please check appropriate box(es):

- |   |                                    |  |                                |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic  | <input type="checkbox"/> Mediterranean     | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American  | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

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

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

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4. Have you or your family recently experienced any major life changes? Yes\_\_\_\_ No\_\_\_\_  
 If yes, please comment: \_\_\_\_\_

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5. 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		
ILLNESSES	WHEN	COMMENTS
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)		

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<b>INJURIES</b>		<b>WHEN</b>	<b>COMMENTS</b>
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
<b>DIAGNOSTIC STUDIES</b>		<b>WHEN</b>	<b>COMMENTS</b>
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.	Other (describe)		

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

<b>WHERE HOSPITALIZED</b>	<b>WHEN</b>	<b>FOR WHAT REASON</b>
a.		
b.		
c.		
d.		
e.		

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

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

7. Are you **allergic to any medications**?

Yes\_\_\_\_ No\_\_\_\_

If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_

8. 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/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

9. 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. As a child did you eat a lot of sugar and/or candy?				

10. a. Have you ever used alcohol?

Yes\_\_\_\_ No\_\_\_\_

b. 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

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c. Have you ever had a problem with alcohol? Yes\_\_\_ No\_\_\_  
If yes, please indicate time period (month/year): from \_\_\_\_\_ to \_\_\_\_\_.

11. Have you ever used recreational drugs? Yes\_\_\_ No\_\_\_

12. 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

13. Are you exposed to second hand smoke regularly? Yes\_\_\_ No\_\_\_

14. Do you have any artificial joints or implants? Yes\_\_\_ No\_\_\_

15. Do you feel worse at certain times of the year? Yes\_\_\_ No\_\_\_  
If yes, when? \_\_\_\_\_spring \_\_\_\_\_fall  
\_\_\_\_\_summer \_\_\_\_\_winter

16. 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: \_\_\_\_\_

17. Hobbies and leisure activities: \_\_\_\_\_  
\_\_\_\_\_

18. Do you exercise regularly? Yes\_\_\_ No\_\_\_  
If so, how many times a week? When you exercise, how long is each session?  
1. \_\_\_\_\_1x 1. \_\_\_\_\_ ≤15 min  
2. \_\_\_\_\_2x 2. \_\_\_\_\_ 16-30 min  
3. \_\_\_\_\_3x 3. \_\_\_\_\_ 31-45 min  
4. \_\_\_\_\_4x or more 4. \_\_\_\_\_ > 45 min

What type of exercise is it?  
\_\_\_\_\_jogging/walking \_\_\_\_\_tennis  
\_\_\_\_\_basketball \_\_\_\_\_water sports  
\_\_\_\_\_home aerobics \_\_\_\_\_other \_\_\_\_\_

19. Any other family history we should know about? Yes\_\_\_ No\_\_\_  
If so, please comment: \_\_\_\_\_