

THE HAVERFORD WELLNESS CENTER

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CONFIDENTIAL HEALTH QUESTIONNAIRE

(PLEASE FAX OR MAIL TO OUR CLINIC BEFORE YOUR APPOINTMENT)

Today's Date \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse's Name OR Parent's Names (if patient is a child) \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

MEDICAL HISTORY

List the main problems that you are having - current medical problems/date started

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Known Allergies to medication and type of reactions to:

\_\_\_\_\_  
\_\_\_\_\_

List Current Medications / Drugs / Hormones and Amount Taking (not nutrients)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LAST NAME: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_

MIDDLEINITIAL: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

## Clinical Hx And Presentation

### Diagnosis:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Presenting Symptoms: \_\_\_\_\_

\_\_\_\_\_

Significant Medical Hx: \_\_\_\_\_

Allergies: (Check all that apply) \_\_\_\_\_

- Beef  Cheese  Chocolate  Citrus  Corn  Eggs  Milk  Mold  Peanuts  Oat  Pork  Shellfish  Wheat  Chemical Sensitivity  Universal Reactor

### Diet Hx: (Check all that apply)

- |                                       |  |  |  |  |   |
|---------------------------------------|--|--|--|--|---|
| <input type="checkbox"/> Low Fat      | <input type="checkbox"/> Vegetarian Diet | <input type="checkbox"/> Gluten Free Diet      | <input type="checkbox"/> Diet Soda         | <input type="checkbox"/> High Juice intake | <input type="checkbox"/> Crave Bacon & Lunch Meat |
| <input type="checkbox"/> Low Carb     | <input type="checkbox"/> Rotation Diet   | <input type="checkbox"/> Generally Good Diet   | <input type="checkbox"/> Nutrasweet        | <input type="checkbox"/> Love ice cream    | <input type="checkbox"/> Love Donuts              |
| <input type="checkbox"/> High Carb    | <input type="checkbox"/> No Meat Diet    | <input type="checkbox"/> Allergy Free Diet     | <input type="checkbox"/> High Caffeine     | <input type="checkbox"/> Love milk         | <input type="checkbox"/> High Sugar Intake        |
| <input type="checkbox"/> Zone Diet    | <input type="checkbox"/> High Fat Diet   | <input type="checkbox"/> Milk/Casein Free Diet | <input type="checkbox"/> Enteral Feed      | <input type="checkbox"/> Restrict Salt     | <input type="checkbox"/> Crave Non-edibles        |
| <input type="checkbox"/> EPD Diet     | <input type="checkbox"/> Always Dieting  | <input type="checkbox"/> High Bread/Pasta Diet | <input type="checkbox"/> Poor Food Choices | <input type="checkbox"/> Avoid Butter      | <input type="checkbox"/> Avoid Eating             |
| <input type="checkbox"/> Low Protein  | <input type="checkbox"/> Ketogenic Diet  | <input type="checkbox"/> Atkins Diet           | <input type="checkbox"/> High Beef Diet    | <input type="checkbox"/> Avoid Vegetables  | <input type="checkbox"/> Over consumption of food |
| <input type="checkbox"/> High Protein | <input type="checkbox"/> Wheat Free Diet | <input type="checkbox"/> Heavy Alcohol         | <input type="checkbox"/> French Fries      | <input type="checkbox"/> Avoid Salads      | <input type="checkbox"/> Microwave used           |

### Dietary Intake: (Circle Low (L), Medium (M), or High (H) intake For only those that pertain!

- |               |       |                |       |                |       |
|---------------|-------|----------------|-------|----------------|-------|
| Sesame Oil    | L M H | MCT Oil        | L M H | Lard           | L M H |
| Safflower Oil | L M H | Soy Oil        | L M H | Crisco         | L M H |
| Flax Oil      | L M H | Cottonseed Oil | L M H | Salad Dressing | L M H |
| Sunflower Oil | L M H | Peanut Oil     | L M H | Mayonnaise     | L M H |
| Walnut Oil    | L M H | Corn Oil       | L M H | Margarine      | L M H |
| Olive Oil     | L M H | Mineral Oil    | L M H | Butter         | L M H |
| Canola Oil    | L M H | Mustard Oil    | L M H | Coconut Butter | L M H |

### Brand Names Used:

- Wesson
- Best Foods
- Hellmann's
- Miracle Whip
- Kraft
- Mazola
- Other \_\_\_\_\_

Fluid Intake: \_\_\_\_\_ Cups of Water \_\_\_\_\_ Cups of Juice \_\_\_\_\_ Cups of Milk \_\_\_\_\_ Cans of Soda \_\_\_\_\_ Cups of Coffee/Tea

### Present Supplements: (Check all that apply)

- |  |                                     |                                  |                                      |                                      |                                    |                                       |                                      |
|--|-------------------------------------|----------------------------------|--------------------------------------|--------------------------------------|------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Acidophilus   | <input type="checkbox"/> Buffered C | <input type="checkbox"/> Choline | <input type="checkbox"/> Omega Brite | <input type="checkbox"/> HCL         | <input type="checkbox"/> MCT Oil   | <input type="checkbox"/> Niacin       | <input type="checkbox"/> Vitamin B12 |
| <input type="checkbox"/> B Complex     | <input type="checkbox"/> Calcium    | <input type="checkbox"/> CoQ10   | <input type="checkbox"/> Enzymes     | <input type="checkbox"/> Iron        | <input type="checkbox"/> MSM       | <input type="checkbox"/> Primrose Oil | <input type="checkbox"/> Vitamin C   |
| <input type="checkbox"/> Black Currant | <input type="checkbox"/> Carnitine  | <input type="checkbox"/> DHA     | <input type="checkbox"/> Fish Oil    | <input type="checkbox"/> Lipoic Acid | <input type="checkbox"/> Multi Min | <input type="checkbox"/> Pyridoxine   | <input type="checkbox"/> Vitamin E   |
| <input type="checkbox"/> Borage Oil    | <input type="checkbox"/> Chlorella  | <input type="checkbox"/> DHEA    | <input type="checkbox"/> Flax Oil    | <input type="checkbox"/> Magnesium   | <input type="checkbox"/> Multi Vit | <input type="checkbox"/> Vitamin A    | <input type="checkbox"/> Zinc        |

Quantity: Flax Oil per day \_\_\_\_\_ Fish Oil per day \_\_\_\_\_ DHA per Day \_\_\_\_\_ Max EPA per day \_\_\_\_\_ Other \_\_\_\_\_

Other Supplements: \_\_\_\_\_

### Present Meds: (Check all that apply)

- |  |  |                                    |                                    |   |  |  |                                       |
|--|--|------------------------------------|------------------------------------|---|--|--|---------------------------------------|
| <input type="checkbox"/> Albuterol       | <input type="checkbox"/> Aspirin             | <input type="checkbox"/> Cortisone | <input type="checkbox"/> DMPS      | <input type="checkbox"/> Klonopin       | <input type="checkbox"/> Nizoral       | <input type="checkbox"/> Prozac        | <input type="checkbox"/> Tylenol      |
| <input type="checkbox"/> Allopurinol     | <input type="checkbox"/> Benzodiazepines     | <input type="checkbox"/> Depakote  | <input type="checkbox"/> Enalapril | <input type="checkbox"/> Lamotrigine    | <input type="checkbox"/> NSAIDs        | <input type="checkbox"/> Risperdal     | <input type="checkbox"/> Valium       |
| <input type="checkbox"/> Analgesics      | <input type="checkbox"/> Beta Blockers       | <input type="checkbox"/> Diflucan  | <input type="checkbox"/> Estrogen  | <input type="checkbox"/> Lasix          | <input type="checkbox"/> Nystatin      | <input type="checkbox"/> Ritalin       | <input type="checkbox"/> Warfarin     |
| <input type="checkbox"/> Antibiotics     | <input type="checkbox"/> Blood Pressure Meds | <input type="checkbox"/> Digitalis | <input type="checkbox"/> HRT       | <input type="checkbox"/> Laxatives      | <input type="checkbox"/> Phenobarbital | <input type="checkbox"/> Sulfa Drugs   | <input type="checkbox"/> Xanax        |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Clozapepam          | <input type="checkbox"/> Dilantin  | <input type="checkbox"/> Heparin   | <input type="checkbox"/> Lithium        | <input type="checkbox"/> Prednisone    | <input type="checkbox"/> Synthroid     | <input type="checkbox"/> Zoloft       |
| <input type="checkbox"/> Antihistamines  | <input type="checkbox"/> Clozapine           | <input type="checkbox"/> Diuretics | <input type="checkbox"/> Inderal   | <input type="checkbox"/> MAO Inhibitors | <input type="checkbox"/> Premarin      | <input type="checkbox"/> Tegretol      | <input type="checkbox"/> Lipitor      |
| <input type="checkbox"/> Armour Thyroid  | <input type="checkbox"/> Codeine             | <input type="checkbox"/> DMSA      | <input type="checkbox"/> Insulin   | <input type="checkbox"/> Mevacor        | <input type="checkbox"/> Provera       | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Street Drugs |

Other Meds: \_\_\_\_\_

**Review of Systems: (Check all that apply)**

**Skin:**

- |   |                                    |   |                                    |  |   |
|---|------------------------------------|---|------------------------------------|--|---|
| <input type="checkbox"/> Acne           | <input type="checkbox"/> Dry       | <input type="checkbox"/> Liver Spots        | <input type="checkbox"/> Rash      | <input type="checkbox"/> White Bumps   | <input type="checkbox"/> Ridged Nails         |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Oily               | <input type="checkbox"/> Redness   | <input type="checkbox"/> White Patches | <input type="checkbox"/> Spoon Shaped Nails   |
| <input type="checkbox"/> Bruising       | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Pale               | <input type="checkbox"/> Rough     | <input type="checkbox"/> Yellow Tone   | <input type="checkbox"/> White Spots on Nails |
| <input type="checkbox"/> Burning Feet   | <input type="checkbox"/> Herpes    | <input type="checkbox"/> Peeling            | <input type="checkbox"/> Skin Tags | <input type="checkbox"/> Bluish Lips   |   |
| <input type="checkbox"/> Cracks         | <input type="checkbox"/> Hives     | <input type="checkbox"/> Poor Wound Healing | <input type="checkbox"/> Vitiligo  | <input type="checkbox"/> Deep Red Lips |   |
| <input type="checkbox"/> Dandruff       | <input type="checkbox"/> Itching   | <input type="checkbox"/> Psoriasis          | <input type="checkbox"/> Warts     | <input type="checkbox"/> Pale Lips     |   |

**Eyes:**

- |   |                                       |                                    |   |  |                                       |                                       |
|---|---------------------------------------|------------------------------------|---|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Bags Under     | <input type="checkbox"/> Cataracts    | <input type="checkbox"/> Diplopia  | <input type="checkbox"/> Floaters       | <input type="checkbox"/> Light Sensitive | <input type="checkbox"/> Sclera blue  | <input type="checkbox"/> Swollen Lids |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Crusty Lids  | <input type="checkbox"/> Discharge | <input type="checkbox"/> Freq. Blinking | <input type="checkbox"/> Pain            | <input type="checkbox"/> Sclera White | <input type="checkbox"/> Tearing      |
| <input type="checkbox"/> Burning        | <input type="checkbox"/> Dark Circles | <input type="checkbox"/> Dyslexia  | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Bloodshot       | <input type="checkbox"/> Styes        |                                       |

**Ears:**

- |                                    |  |                                    |  |  |                                   |
|------------------------------------|--|------------------------------------|--|--|-----------------------------------|
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Excessive Wax | <input type="checkbox"/> Infection | <input type="checkbox"/> Red Ear Lobes | <input type="checkbox"/> Sound Sensitive | <input type="checkbox"/> Vertigo  |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Hearing Loss  | <input type="checkbox"/> Itching   | <input type="checkbox"/> Ringing       | <input type="checkbox"/> Tinnitus        | <input type="checkbox"/> Pressure |

**Nose & Sinuses:**

- |                                    |                                      |                                       |                                      |  |                                     |
|------------------------------------|--------------------------------------|---------------------------------------|--------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Crusts    | <input type="checkbox"/> Freq. Colds | <input type="checkbox"/> Itching      | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Stuffiness |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Hayfever    | <input type="checkbox"/> Mucus Yellow | <input type="checkbox"/> Polyps      | <input type="checkbox"/> Sneezing      | <input type="checkbox"/> Asthma HX  |

**Mouth & Throat:**

- |  |  |  |  |                                      |  |   |
|--|--|--|--|--------------------------------------|--|---|
| <input type="checkbox"/> Amalgams      | <input type="checkbox"/> Canker Sores  | <input type="checkbox"/> Silver Fillings   | <input type="checkbox"/> Gag Easily    | <input type="checkbox"/> Grind Teeth | <input type="checkbox"/> Lines on Tongue | <input type="checkbox"/> Mouth Ulcers   |
| <input type="checkbox"/> Bad Breath    | <input type="checkbox"/> Chapped Lips  | <input type="checkbox"/> Dentures          | <input type="checkbox"/> Gingivitis    | <input type="checkbox"/> Hoarseness  | <input type="checkbox"/> Lips Crack      | <input type="checkbox"/> Red Tip Tongue |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Coated Tongue | <input type="checkbox"/> Drooling          | <input type="checkbox"/> Glossy Tongue | <input type="checkbox"/> Implants    | <input type="checkbox"/> Magenta Tongue  | <input type="checkbox"/> Root Canals    |
| <input type="checkbox"/> Bridges       | <input type="checkbox"/> Crowns        | <input type="checkbox"/> Freq Sore Throats | <input type="checkbox"/> Gold Fillings | <input type="checkbox"/> Infections  | <input type="checkbox"/> Metal Braces    | <input type="checkbox"/> Sore Tongue    |

**Respiratory:**

- |                                 |                                     |   |                                    |  |  |                     |
|---------------------------------|-------------------------------------|---|------------------------------------|--|--|---------------------|
| <input type="checkbox"/> Apnea  | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cough                | <input type="checkbox"/> Pleurisy  | <input type="checkbox"/> Shortness in Breath | <input type="checkbox"/> Smoke: Y or N | Packs per Day _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congestion | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Wheeze              |  |                     |

**Cardiac:**

- |   |                                  |   |                                   |                                       |   |
|---|----------------------------------|---|-----------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Flushing of Skin | <input type="checkbox"/> High B/P | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Atherosclerosis: Y/N _____ |
| <input type="checkbox"/> Chest Pain       | <input type="checkbox"/> Edema   | <input type="checkbox"/> Heart Murmur     | <input type="checkbox"/> Low B/P  | <input type="checkbox"/> Tight Chest  | <input type="checkbox"/> HX of Heart Surgery _____  |

**Gastrointestinal:**

- |   |                                       |  |   |  |  |  |
|---|---------------------------------------|--|---|--|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Bloating     | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Gall Bladder Removed | <input type="checkbox"/> Ingestion       | <input type="checkbox"/> Nausea        | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Anal Itching   | <input type="checkbox"/> Colitis      | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Heartburn            | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Regurgitation | <input type="checkbox"/> Vomiting        |
| <input type="checkbox"/> Belching       | <input type="checkbox"/> Constipation | <input type="checkbox"/> Flatulence            | <input type="checkbox"/> Hemorrhoids          | <input type="checkbox"/> Mucus           | <input type="checkbox"/> Tan Stool     | <input type="checkbox"/> Fat intolerance |

**Urinary:**

- |                                   |                                    |                                       |   |                                   |                                     |  |
|-----------------------------------|------------------------------------|---------------------------------------|---|-----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Frequency | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polyuria | <input type="checkbox"/> Urgency    | <input type="checkbox"/> Dark Yellow Urine |
| <input type="checkbox"/> Cystitis | <input type="checkbox"/> Hesitancy | <input type="checkbox"/> Infections   | <input type="checkbox"/> Nocturia       | <input type="checkbox"/> Stones   | <input type="checkbox"/> Pale Urine |  |

**Genital (male):**

- |   |                                      |  |  |  |
|---|--------------------------------------|--|--|--|
| <input type="checkbox"/> Discharge      | <input type="checkbox"/> Impotence   | <input type="checkbox"/> Itching           | <input type="checkbox"/> Prostatic Hypertrophy | <input type="checkbox"/> Testicular Pain |
| <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Infertility | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Sores                 | <input type="checkbox"/> Infection       |

**Genital (female):**

- |  |   |   |  |  |   |
|--|---|---|--|--|---|
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Endometriosis      | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Infertility     | <input type="checkbox"/> Menopausal Symptoms | <input type="checkbox"/> Tender Breasts   |
| <input type="checkbox"/> Discharge           | <input type="checkbox"/> Excess Hair Growth | <input type="checkbox"/> Hot Flashes    | <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> PMS                 | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Dysmenorrhea        | <input type="checkbox"/> Low Libido         | <input type="checkbox"/> Hysterectomy   | <input type="checkbox"/> Itching         | <input type="checkbox"/> Spotting            | <input type="checkbox"/> Excess Bleeding  |

**Musculoskeletal:**

- |                                    |                                       |  |   |  |  |
|------------------------------------|---------------------------------------|--|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> CP           | <input type="checkbox"/> Hx of Fractures | <input type="checkbox"/> Joint Swelling       | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Spasticity                  |
| <input type="checkbox"/> Atrophy   | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Hypotonia       | <input type="checkbox"/> Limited Range/Motion | <input type="checkbox"/> Rigidity        | <input type="checkbox"/> Stiffness                   |
| <input type="checkbox"/> Backache  | <input type="checkbox"/> Gout         | <input type="checkbox"/> Joint Pain      | <input type="checkbox"/> Muscle Pain          | <input type="checkbox"/> Spasms          | <input type="checkbox"/> Uneven Muscular Development |

**Neurologic:**

- |  |   |  |  |  |  |  |
|--|---|--|--|--|--|--|
| <input type="checkbox"/> Abnormal Gait | <input type="checkbox"/> Confusion            | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Poor Dream Recall | <input type="checkbox"/> Shaky Feeling | <input type="checkbox"/> Unprovoked Anger  |
| <input type="checkbox"/> ADD           | <input type="checkbox"/> Delusional           | <input type="checkbox"/> Hyperactivity     | <input type="checkbox"/> Mood Swings       | <input type="checkbox"/> Poor Memory       | <input type="checkbox"/> Speech Delay  | <input type="checkbox"/> Weakness          |
| <input type="checkbox"/> ADHD          | <input type="checkbox"/> Depression           | <input type="checkbox"/> Impulsiveness     | <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Rage Behavior     | <input type="checkbox"/> Tension       | <input type="checkbox"/> Withdrawal        |
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Disoriented          | <input type="checkbox"/> Insomnia          | <input type="checkbox"/> Nightmares        | <input type="checkbox"/> Restlessness      | <input type="checkbox"/> Tics          | <input type="checkbox"/> Autistic Features |
| <input type="checkbox"/> Apathy        | <input type="checkbox"/> Excessive Sleepiness | <input type="checkbox"/> Irritable         | <input type="checkbox"/> Numbness          | <input type="checkbox"/> Sciatica          | <input type="checkbox"/> Tingling      | <input type="checkbox"/> Fasciculation     |
| <input type="checkbox"/> Brain Fog     | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Poor Coordination | <input type="checkbox"/> PDD               | <input type="checkbox"/> Seizures          | <input type="checkbox"/> Tremors       | <input type="checkbox"/> Unable to Walk    |

**Endocrine:**

- |   |   |   |                                       |  |                                      |
|---|---|---|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Coarse Features  | <input type="checkbox"/> Edema              | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> HRT          | <input type="checkbox"/> Hypothyroid         | <input type="checkbox"/> Underweight |
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Excessive Hunger   | <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Poor Carb Tolerance | <input type="checkbox"/> Diabetes Hx |
| <input type="checkbox"/> Dysinsulism      | <input type="checkbox"/> Excessive Swelling | <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Overweight          |                                      |

**Immune:**

- |   |  |   |  |  |  |
|---|--|---|--|--|--|
| <input type="checkbox"/> Autoimmune             | <input type="checkbox"/> Cancer Hx       | <input type="checkbox"/> Hepatitis Hx         | <input type="checkbox"/> Lupus           | <input type="checkbox"/> Recurrent Illness | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Breast Implants        | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Infection            | <input type="checkbox"/> Lyme Hx         | <input type="checkbox"/> Swollen Glands    |  |
| <input type="checkbox"/> Allergic to everything | <input type="checkbox"/> CFS Hx          | <input type="checkbox"/> Chemical Intolerance | <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Universal Reactor |  |

Please indicate past or present amounts:

	Daily	Weekly	Occasionally	Never	Past
Coffee/caffeine					
Tobacco (___ packs/day)					
Alcohol					
Aspirin					
Laxatives					
Exercise					
Meditation					

Date of last complete checkup \_\_\_\_\_ Results \_\_\_\_\_

Names of recent Doctors consulted \_\_\_\_\_

Are you willing to change your lifestyle/habits to improve your health?  Yes  No

Have you had adjustments or other treatments for your neck or back?  Yes  No

Do you follow a special diet?  Yes  No    Organic certified?  Yes  No

Do you react to pollen?  Yes  No    Reaction \_\_\_\_\_

Do you react to foods?  Yes  No    Reaction \_\_\_\_\_

List any chemicals, metals, dusts, molds, or fumes to which you are repeatedly exposed: \_\_\_\_\_

Do you know your blood type? (Circle One)    O    A    B    AB    (Circle One)    Positive or Negative

Does your spiritual life play an important role in your life?  Yes  No

First Partnered \_\_\_\_\_ Number of years \_\_\_\_\_    Divorced/separated \_\_\_\_\_    When \_\_\_\_\_

Number of children \_\_\_\_\_    Ages/Gender \_\_\_\_\_

WOMEN ONLY

Number of children \_\_\_\_\_    Ages/Gender \_\_\_\_\_    Adopted \_\_\_\_\_

Number of:    Pregnancies \_\_\_\_\_    Deliveries \_\_\_\_\_    Miscarriages \_\_\_\_\_    Abortions \_\_\_\_\_

Do you use a contraceptive?  Yes  No    If so, what type \_\_\_\_\_

Last PAP smear \_\_\_\_\_    Result \_\_\_\_\_    Last mammogram \_\_\_\_\_    Result \_\_\_\_\_

Have you had a scan DEXA for bone density?  Yes  No    Result \_\_\_\_\_

Are you taking hormone replacement therapy?  Yes  No    What form? \_\_\_\_\_

\_\_\_\_\_

## FAMILY HISTORY

If family members have any of the following please identify which by the following:  
 (Mother=M, Father=F, Brother=B, Sister=S, Grandparent=G, Child=C, Aunt=A, Uncle=U)

- |                          |                            |                              |
|--------------------------|----------------------------|------------------------------|
| 1. ___ Allergies         | 7. ___ Stroke              | 13. ___ Cancer               |
| 2. ___ Alcoholism        | 8. ___ High blood pressure | Type/s _____                 |
| 3. ___ Asthma            | 9. ___ Hypoglycemia        | 14. ___ Kidney disease       |
| 4. ___ Bleeding Disorder | 10. ___ Diabetes           | 15. ___ Psychiatric disorder |
| 5. ___ Epilepsy          | 11. ___ Neurologic disease | 16. ___ Lung disease         |
| 6. ___ Heart Disease     | 12. ___ Tuberculosis       | 17. ___ Other _____          |

Do you have any of the above?  Yes  No If so which \_\_\_\_\_

Check if you have ever had any of the following.

- |                             |                                    |                         |
|-----------------------------|------------------------------------|-------------------------|
| 1. ___ Cataracts            | 6. ___ Loss of libido or sex drive | 11. ___ Liver disease   |
| 2. ___ Back Problems        | 7. ___ Ulcers                      | 12. ___ Herpes          |
| 3. ___ Gall bladder Trouble | 8. ___ Rheumatic fever             | 13. ___ Lyme Disease    |
| 4. ___ Seizures             | 9. ___ Scarlet fever               | 14. ___ Cancer: type of |
| 5. ___ Insomnia             | 10. ___ Thyroid disease            | _____                   |

## REVIEW OF SYSTEMS:

Please list any symptoms that you have now or experienced: (Please check past or present and how severe and frequent the problem-specify which by circling)

	Past	Present	How severe	How Frequent
1. Headaches	<input type="checkbox"/>	<input type="checkbox"/>		_____
2. Problems with vision, hearing, taste or smell	<input type="checkbox"/>	<input type="checkbox"/>		_____
3. Chest Pain or shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		_____
4. Cough, wheezing or other breathing difficulties	<input type="checkbox"/>	<input type="checkbox"/>		_____
5. Heartburn, gas, bloating, indigestion	<input type="checkbox"/>	<input type="checkbox"/>		_____
6. Constipation, diarrhea, hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>		_____
7. Urinary tract problems, stones, infections in the bladder or kidney	<input type="checkbox"/>	<input type="checkbox"/>		_____
8. Gynecologic problems(specify)	<input type="checkbox"/>	<input type="checkbox"/>		_____
9. Infertility, impotence, low libido	<input type="checkbox"/>	<input type="checkbox"/>		_____
10. Skin or hair problems	<input type="checkbox"/>	<input type="checkbox"/>		_____
11. Bone or joint disorders	<input type="checkbox"/>	<input type="checkbox"/>		_____
12. Neurological problems, Fasciculations	<input type="checkbox"/>	<input type="checkbox"/>		_____
13. Mood, emotion, or psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>		_____
14. Fatigue, night sweats, loss of motivation	<input type="checkbox"/>	<input type="checkbox"/>		_____



PATIENT'S NAME: \_\_\_\_\_

**BODYBIO DIETARY HISTORY FORM**

PLEASE FILL OUT THE FOLLOWING WITH WHAT YOUR DIET CONSISTS OF ON AN AVERAGE DAY. PLEASE BE AS SPECIFIC (AND HONEST) AS POSSIBLE!

**BREAKFAST:** \_\_\_\_\_

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**SNACK:** \_\_\_\_\_

---

---

**LUNCH:** \_\_\_\_\_

---

---

**SNACK:** \_\_\_\_\_

---

---

**DINNER:** \_\_\_\_\_

---

---

**SNACK:** \_\_\_\_\_

---

---

PAST HISTORY

Please list all Accidents and Injuries:

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---

Please List all Surgeries:

---

---

---

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Please list all Countries you have Traveled to or Lived in the Past:

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Where was your place of birth? \_\_\_\_\_

States where you lived in the past: \_\_\_\_\_

Do you see a dentist regularly?\_\_\_\_\_ Name of Dentist:\_\_\_\_\_

How many silver fillings did you have?\_\_\_ How many silver fillings do you have now? \_\_\_

How many root canals do you have?\_\_\_\_\_ Any tooth implants? \_\_\_\_\_

Have you had your fillings removed? \_\_\_\_\_ When? \_\_\_\_\_ Natural Dentist?\_\_\_\_\_

What is your primary source of water? (Circle One) Tap Well Bottled Filtered

How did you hear about us?

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Do you have or have you had a toxic exposure such as mold in your home? Which one?

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What are your goals to improve your health?

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Thank you for taking the time to complete this form. It is the beginning of your process of healing and health.

Domenick Braccia, D.O. and. Patricia Kane, Ph.D.