MONTGOMERY
INTEGRATIVE HEALTH
GROUP
WHOLE PERSON HEALTHCARE

Heidi L. Wittels, MD, ABOIM, ABIHM **Daila Pravs, MD, ABFM, ABIHM**

PATIENT'S NAME: _____
First **Last** **Middle**

SS#: _____ **DATE OF BIRTH**: _____

RACE: Asian Black Caucasian Hispanic **CASE**: **WORKERS COMP** _____
Indian Arab Other _____ **AUTO ACCIDENT** _____

MARITAL STATUS: Single _____ Married _____ Divorced _____
Widowed _____ Separated _____ Other _____

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP CODE** _____

HOME PHONE: _____ **WORK PHONE**: _____

E-MAIL ADDRESS: _____ **CELL PHONE**: _____

EMPLOYER'S NAME: _____

REFERRING PHYSICIAN: Phone #:

Address: _____ Fax #: _____

PRIMARY PHYSICIAN: _____ Phone # _____

Address: _____ Fax #: _____

PHARMACY: Name_____ Phone: _____

PHARMACY: Address _____

EMERGENCY CONTACT:_____**Relationship**_____**HOME PHONE #:** _____

ADDRESS: _____ **WORK PHONE #:** _____

PRIMARY INSURANCE	AUTO / WORKERS' COMP / SECONDARY
COMPANY	**COMPANY**
ADDRESS	**ADDRESS**
INSURANCE ID#	**CLAIM #**
GROUP #	**ADJUSTER**
PHONE #	**PHONE #**
SUBSCRIBER'S NAME	**DATE OF ACCIDENT**
DATE OF BIRTH	**ATTORNEY**

1108 E. Willow Grove Avenue. Wyndmoor, PA 19038
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MONTGOMERY INTEGRATIVE HEALTH, LLC

MEDICAL INTAKE FORM

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. The more you complete, the better we can help you.

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Place of Birth (city or town & country if not U.S.): _____

Referred by: _____ Height: _____ Weight _____ Sex: _____

Who else gets a copy of medical reports? _____
Include phone number and address _____

Please check appropriate box(es):

☐ African American	☐ Hispanic	☐ Mediterranean	☐ Asian
☐ Native American	☐ Caucasian	☐ Northern European	☐ Other

---- *For Doctor's Use*----
HISTORY OF PRESENT ILLNESS: _____

COMPLAINTS/CONCERNS:

What do you hope to achieve in your visit? _____

If you had a magic wand and could erase three problems, what would they be?
1. _____
2. _____
3. _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

_____

What makes you feel worse? _____

_____

What makes you feel better? _____

_____

Please list current and ongoing problems in order of priority:

DESCRIBE PROBLEM	MILD/MODERATE/ SEVERE	PRIOR TREATMENT/APPROACH	BARRIER TO IMPROVEMENT
Example: Post Nasal Drip	*Moderate*	*Elimination Diet*	

PAST MEDICAL HISTORY/TESTING:

ILLNESSES/CONDITIONS	WHEN	DOCTOR'S COMMENTS
Amputation		
Anemia		
Anxiety/Depression/Insomnia		
Arthritis (rheumatoid, osteoarthritis)		
Asthma		
Bronchitis		
Bursitis/Tendonitis		
Cancer		
Chrohn's Disease or Ulcerative Colitis		
Chronic Fatigue Syndrome/Fibromyalgia		
Chronic pain		
Diabetes		
Emphysema, COPD		
Epilepsy, convulsions or seizures		
Gallstones		
Gout		
Heart: Attack/Angina/Failure/Arrhythmia/ Valve		
Hepatitis		
High blood fats (cholesterol, triglycerides)		
High blood pressure		
Irritable bowel/Ulcer/Hernia		
Joint contracture		
Kidney stones		
Lyme disease		
Mononucleosis		
Multiple sclerosis		
Muscle disease		

ILLNESSES/CONDITIONS (cont.)	WHEN	DOCTOR'S COMMENTS
Nerve injury		
Parkinson's disease		
Peripheral vascular disease		
Pneumonia		
Restless leg syndrome		
Rheumatic fever		
Sinusitis		
Skin problem/Infection		
Sleep apnea or other sleep disorder		
Spine or disc disorder		
Stroke		
Thyroid disease		
Other (describe)		

INJURIES	WHEN	COMMENTS	DOCTOR'S COMMENTS
Broken bone (describe)			
Head injury/Brain injury			
Other (describe)			
Car accident(s)? How many? _____ Were you the driver? _____ Seat belt on? _____			
DIAGNOSTIC STUDIES			
Barium Enema			
Bone Scan			
CAT Scan (of what?)			
Ultrasound			
X-ray (of what?)			
Colonoscopy			
EKG/Echocardiogram			
Liver Scan			
MRI			
Upper GI Series			
EMG/NCS			
OPERATIONS			
Appendectomy			
Dental Surgery			
Gall Bladder			
Hernia			
Hysterectomy			
Tonsillectomy			
Arthroscopy			
Injections (of what?)			
Other (describe)			

CHILDHOOD HISTORY:

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?				

CHILDHOOD ILLNESSES:

As a child, were there any foods that you had to avoid because they gave you symptoms? ☐ Yes ☐ No
If yes, please name the food and symptom (Example: milk-- gas and diarrhea) _____
_____
_____

GYNECOLOGIC HISTORY: *(for women only)*

Have you ever been pregnant? ☐ Yes ☐ No
Number of miscarriages _____ Number of abortions _____ Number of preemies _____
Number of term births _____ Birth weight of largest baby _____ Smallest baby _____
Did you develop toxemia (high blood pressure)? ☐ Yes ☐ No
Postpartum depression? ☐ Yes ☐ No
Gestational diabetes? ☐ Yes ☐ No
Problems with breast feeding? ☐ Yes ☐ No

Did you have other problems with pregnancy? ☐ Yes ☐ No If yes, please comment:
_____
_____

Age at first period _____ Date of last Pap smear _____ Date of last mammogram _____
Pap Smear: ☐ Normal ☐ Abnormal Mammogram: ☐ Normal ☐ Abnormal

Have you ever used birth control pills? ☐ Yes ☐ No If yes, when? _____
Are you taking the pill now? ☐ Yes ☐ No
Did taking the pill agree with you? ☐ Yes ☐ No ☐ Not applicable

Do you currently use contraception? ☐ Yes ☐ No
If yes, what type of contraception do you use? _____

Are you in menopause? ☐ Yes ☐ No If yes, age at last period _____ Skipped periods? ☐ Yes ☐ No
Do you take: ☐ Estrogen ☐ Ogen ☐ Estrace ☐ Premarin ☐ Progesterone ☐ Provera
☐ Other (specify) _____

How long have you been on hormone replacement therapy (if applicable)? _____

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?
☐ Yes ☐ No ☐ Not applicable

Do you have fibrocystic breasts? ☐ Yes ☐ No Endometriosis? ☐ Yes ☐ No
Date of last mammogram _____

Date of last bone density test _____

Sex: ☐ Change in libido ☐ Difficulty maintaining lubrication ☐ Difficulty achieving climax
☐ Pain with intercourse

MEN'S HISTORY: *(for men only)*

Have you had a PSA done? ☐ Yes ☐ No
PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ > 10

Do you have:
☐ Prostate enlargement ☐ Prostate infection ☐ Change in libido
☐ Difficulty obtaining an erection ☐ Difficulty maintaining an erection ☐ Difficulty achieving climax

REVIEW OF SYSTEMS:
Please check if these symptoms occur presently or have occurred in the past 6 months.

GENERAL	Mild	Moderate	Severe	Doctor's Comments
Cold hands & feet				
Cold intolerance				
Daytime sleepiness				
Difficulty falling asleep				
Early waking				
Fatigue				
Fever/Chills				
Flushing				
Heat intolerance				
Lumps/Masses				
Night waking				
Nightmares				
No dream recall				
Palpitations				
Shortness of breath/ wheeze				
Snoring				
Unrefreshed				

HEAD, EYES & EARS				
Conjunctivitis				
Distorted sense of smell				
Distorted taste				
Dry eyes				
Ear fullness				
Ear noises				
Ear pain				
Ear ringing/buzzing				
Eye crusting				
Eye pain				
Headache				
Hearing loss				
Hearing problems				
Lid margin redness				
Migraine				
Sensitivity to loud noises				
Vision problems (double, blurred, loss)				

MUSCULOSKELETAL	Mild	Moderate	Severe	Doctor's Comments
Back muscle spasm				
Calf cramps				
Chest tightness				
Foot cramps				
Joint deformity				
Joint pain				
Joint redness				
Joint stiffness				
Muscle pain				
Muscle spasms				
Muscle stiffness				
Muscle twitches:				
Around eyes				
Arms or legs				
Muscle weakness				
Neck muscle spasm				
Swelling				
Tendonitis				
Tension headache				
TMJ problems				

MOOD/NERVES				
Agoraphobia				
Anxiety/Panic attacks				
Auditory hallucinations				
Blackout				
Depression				
Difficulty:				
Concentrating				
With balance				
With thinking				
With judgment				
With speech				
With memory				
Dizziness (spinning)				
Fainting				
Falls/Decreased balance				
Fearfulness				
Irritability				
Lightheadedness				
Loss of consciousness				
Numbness/Tingling				
Other Phobias				
Paranoia				
Seizures				
Spasms				
Suicidal thoughts				
Tremor/trembling				
Visual hallucinations				
Weakness				

EATING	Mild	Moderate	Severe	Doctor's Comments
Binge eating				
Bulimia				
Can't gain weight				
Can't lose weight				
Carbohydrate craving				
Carbohydrate intolerance				
Poor appetite				
Salt craving				

DIGESTION				
Abdominal pain				
Anal spasms				
Bad teeth				
Bleeding gums				
Bloating of:				
Lower abdomen				
Whole abdomen				
Blood in stools				
Burping				
Canker sores				
Cold sores				
Constipation				
Cracking at corner of lips				
Dentures w/poor chewing				
Diarrhea/Loss of control				
Difficulty swallowing				
Dry mouth				
Farting/Gas				
Fissures				
Foods "repeat" (reflux)				
Heartburn				
Hemorrhoids				
Intolerance to: Lactose				
All milk products				
Intolerance to:				
Gluten (wheat)				
Corn				
Eggs				
Fatty foods				
Yeast				
Liver disease/jaundice *(yellow eyes or skin)*				
Lower abdominal pain				
Mucus in stools				
Nausea/Vomiting				
Periodontal disease				
Sore tongue				
Strong stool odor				
Undigested food in stools				

SKIN PROBLEMS	Mild	Moderate	Severe	Doctor's Comments
Acne on back				
Acne on chest				
Acne on face				
Acne on shoulders				
Athlete's foot				
Cellulite				
Bumps on back of upper arms				
Dark circles under eyes				
Ears get red				
Easy bruising				
Eczema				
Herpes - genital				
Hives				
Jock itch				
Lackluster skin				
Moles w/color/size change				
Oily skin				
Pale skin				
Patchy dullness				
Psoriasis				
Rash				
Red face				
Sensitive to bites				
Sensitive to poison ivy/oak				
Shingles				
Skin cancer				
Skin darkening				
Strong body odor				
Thick calluses				
Vitiligo				

SKIN, ITCHING				
Anus				
Arms				
Ear canals				
Eyes				
Feet				
Hands				
Legs				
Nippies				
Nose				
Penis				
Roof of mouth				
Scalp				
Skin in general				
Throat				

SKIN, DRYNESS OF	Mild	Moderate	Severe	Doctor's Comments
Eyes				
Feet				
Any cracking?				
Any peeling?				
Hair				
And unmanageable?				
Hands				
Any cracking?				
Any peeling?				
Mouth/throat				
Scalp				
Any dandruff?				
Skin in general				

LYMPH NODES				
Enlarged/neck				
Tender/neck				
Other enlarged/tender lymph nodes				

NAILS				
Bitten				
Brittle				
Curve up				
Frayed				
Fungus – fingers				
Fungus – toes				
Pitting				
Ragged cuticles				
Ridges				
Soft				
Thickening of: Finger nails				
Toenails				
White spots/lines				

RESPIRATORY				
Bad breath				
Bad odor in nose				
Cough – dry				
Cough – productive				
Hay fever: Spring				
Summer				
Fall				
Change of season				
Hoarseness				
Nasal stuffiness				
Nose bleeds				
Post nasal drip				
Sinus fullness				
Sinus infection				

RESPIRATORY(cont.)	Mild	Moderate	Severe	Doctor's Comments
Snoring				
Sore throat				
Wheezing				
Winter stuffiness				

CARDIOVASCULAR				
Angina/chest pain				
Breathlessness				
Heart attack				
Heart murmur				
High blood pressure				
Irregular pulse				
Mitral valve prolapse				
Palpitations				
Phlebitis				
Swollen ankles/feet				
Varicose veins				

URINARY				
Bed wetting				
Blood in urine				
Foley catheter				
Hesitancy/Retention				
Infection				
Kidney disease				
Kidney stone				
Leaking/incontinence				
Night-time urination				
Pain/burning				
Prostate enlargement				
Prostate infection				
Urgency/Frequency				

MALE REPRODUCTIVE				
Discharge from penis				
Ejaculation problem				
Genital pain				
Infection				
Lumps in testicles				

FEMALE REPRODUCTIVE				
Breast cysts				
Breast lumps				
Breast tenderness				
Ovarian cyst				
Endometriosis				
Fibroids				
Infertility				
Vaginal discharge				

FEMALE REPRODUCTIVE (cont.)	Mild	Moderate	Severe	Doctor's Comments
Vaginal odor				
Vaginal itch				
Vaginal pain				
Premenstrual:				
Bloating				
Breast tenderness				
Carbohydrate craving				
Chocolate craving				
Constipation				
Decreased sleep				
Diarrhea				
Fatigue				
Increased sleep				
Irritability				
Menstrual:				
Cramps				
Heavy periods				
Irregular periods				
No periods				
Scanty periods				
Spotting between				

ALLERGIES:

Are you allergic to any medications/supplements/food/environment? ☐ Yes ☐ No

ALLERGEN	REACTION

MEDICATIONS/SUPPLEMENTS:

How often have you taken antibiotics?

	< 5 times	> 5 times
Infancy / Childhood		
Teen		
Adulthood		

How often have you taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	> 5 times
Infancy / Childhood		
Teen		
Adulthood		

Medications tried that didn't help: _____

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

Medication	Date Started	Dosage

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

NUTRITION HISTORY:

What special dietary/fluid intake strategies or restrictions do you follow? _____

_____

Describe what you might eat for breakfast, lunch and dinner.

Breakfast	Lunch	Dinner

How much of the following do you consume each week?

	None	A Little	Moderate Amount	A Lot
Candy				
Cheese				
Chocolate				
Cups of coffee containing caffeine				
Cups of decaffeinated coffee or tea				
Cups of hot chocolate				
Cups of tea containing caffeine				
Diet sodas				
Ice cream				

	None	A Little	Moderate Amount	A Lot
Salty foods				
Slices of white bread (rolls/bagels)				
Sodas with caffeine				
Sodas without caffeine				

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? ☐ Yes ☐ No
If yes, are these symptoms associated with any particular food or snpplement(s)? ☐ Yes ☐ No
Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea. _____

_____

_____

Do you adversely react to: *Check all that apply*
☐ Monosodium glutamate (MSG) ☐ Aspartame (Nutrasweet) ☐ Caffeine ☐ Bananas
☐ Garlic ☐ Onion ☐ Cheese ☐ Citrus foods ☐ Chocolate ☐ Alcohol ☐ Red wine
☐ Sulfate containing foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. Sodium benzoate)
☐ Other _____

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? ☐ Yes ☐ No

Do you feel much worse when you eat a lot of:
☐ high fat foods
☐ high protein foods
☐ high carbohydrate foods (breads, pastas, potatoes)
☐ refined sugar (junk food)
☐ fried foods
☐ 1 or 2 alcoholic drinks
☐ Other _____

Do you feel much better when you eat a lot of:
☐ high fat foods
☐ high protein foods
☐ high carbohydrate foods (breads, pastas, potatoes)
☐ refined sugar (junk food)
☐ fried foods
☐ 1 or 2 alcoholic drinks
☐ Other _____

Does skipping a meal greatly affect your symptoms? ☐ Yes ☐ No
Have you ever had a food that you craved or really "binged" on over a period of time? ☐ Yes ☐ No
(Food craving may be an indicator that you may be allergic to that food.)
If yes, whatfood(s)? _____

_____

SOCIAL HISTORY:

Work History

Do you like the work you do? ☐ Yes ☐ No

Do you like your boss? ☐ Yes ☐ No

What do you do? _____ Last day of work_____

What is the most strenuous physical task that you MUST do? _____
Duration/frequency? _____

What physical restrictions do you follow? _____

Smoking

Are you currently smoking? ☐ Yes ☐ No Packs per day _____ Number of attempts to quit _____
Previous Smoking: How many years? _____ Packs per day _____ Second hand smoke exposure? _____

Alcohol Intake

How many drinks currently per week? *(1 drink = 5 oz. wine, 12 oz. beer, 1.5 oz. spirits)*
☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 If "none", skip to Other Substances

Previous alcohol intake? ☐ Yes (☐ Mild ☐ Moderate ☐ High) ☐ None

Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No

Do you get annoyed when people ask you about your drinking? ☐ Yes ☐ No

Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you ever take an eye-opener? ☐ Yes ☐ No

Do you notice a tolerance to alcohol (can you "hold" more than others)? ☐ Yes ☐ No

Have you ever been unable to remember what you did during a drinking episode? ☐ Yes ☐ No

Do you get into arguments or physical fights when you have been drinking? ☐ Yes ☐ No

Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

Other Substances

Are you currently using any recreational drugs? ☐ Yes ☐ No Type _____

What recreational/illicit drugs have you used in the past? _____

Exercise

Current Exercise Program: *Activity (list type, number of sessions per week and duration of activity)*

Activity	Type	Frequency per Week	Duration in Minutes	Are You Independent With
Stretching				
Cardio/Aerobics				
Strength				
Other (yoga, pilates, gyrotonics, aquatic)				
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)				
Modalities (heat, ice, electrical stimulation, massage, acupuncture, manipulation, other)				

Rate your level of motivation for including exercise in your life. ☐ Low ☐ Medium ☐ High

List problems that limit activity:_____

_____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No
If yes, please describe:_____

_____

Do you usually sweat when exercising? ☐ Yes ☐ No

Psychosocial

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

_____

Who can help you 24 hours per day? _____

Must you climb stairs at home? ☐ Yes ☐ No Are there handrails? ☐ Yes ☐ No

Elevator? ☐ Yes ☐ No Conld yon stay on the first floor if it were necessary? ☐ Yes ☐ No

What services do you receive at home? _____
In the community? _____

What transportation do you use?_____

Have yon lived or traveled outside of the United States? ☐ Yes ☐ No
If so, when and where?_____

_____

Have you or your family recently experienced any major life changes? ☐ Yes ☐ No
If yes, please comment:_____

_____

Have you experienced any major losses in life? ☐ Yes ☐ No
Ifso,pleaseconnment: _____

_____

How important is religion (or spirituality) for you and your family's life?
☐ not at all important ☐ somewhat important ☐ extremely important

Unfortunately, abuse and violence of all kinds—verbal, emotional, physical and sexual—are leading contributors to chronic stress, illness, and immnne system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes. We will respect your privacy as you request.

Please do your best to answer the following questions:

Did you feel safe growing up? ☐ Yes ☐ No

Have you been involved in abusive relationships in your life? ☐ Yes ☐ No

Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
☐ Yes ☐ No

Do you currently feel safe in your home? ☐ Yes ☐ No

Do you feel safe, respected and valued in your current relationship? ☐ Yes ☐ No

Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
☐ Yes ☐ No

Would you feel safer discussing any of these issues privately? ☐ Yes ☐ No

How many tattoos do you have? _____

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No

Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐ Yes ☐ No

How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does Not Apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend/spouse					
With your children					
With your parents					

Have you ever had psychotherapy or counseling? ☐ Yes ☐ No
☐ Currently? ☐ Previously? If previously, from _____ to _____
Whatkin d? _____
Comments: _____

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
Comments: _____

FUNCTIONAL HISTORY:

When was your last fall? _____
How did it happen? _____
What injury did you sustain? _____

Activity	Unable	Difficult	Normal	Activity	Unable	Difficult	Normal
Getting in/out of bed				Grooming			
Getting in/out of chair				Cooking			
Sitting (how long, maximally?_____)				Cleaning			
Walking (how far, maximally?_____)				Laundry			
Going up/down stairs				Shopping			
Bathing				Finances			
Dressing				Traveling			
Hygiene				Sexual Activity			
Feeding				Lifting/carrying			
Taking medications							

Devices Used: ☐ Brace/prosthesis ☐ Corset/collar ☐ Cane ☐ Walker
☐ Wheelchair ☐ Scooter ☐ Commode ☐ Shower seat ☐ Hospital bed

Specify: _____

TOXIC EXPOSURE:

When you drink caffeine do you feel: ☐ Irritable or wired ☐ Aches and pains

Which of these significantly affect you? *Check all that apply*
☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other_____

In your work or home environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

Have you ever been told you have Gilbert's syndrome or a liver disorder? ☐ Yes ☐ No
Explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:
☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides ☐ Organic Solvents
☐ Heavy Metals ☐ Other _____

Chemical name, date, length of exposure_____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? ☐ Yes ☐ No

Do you have any pets or farm animals? ☐ Yes ☐ No

Do you have any artificial joints or implants? ☐ Yes ☐ No

Do you feel worse at certain times of the year? ☐ Yes ☐ No
If yes, when? ☐ Spring ☐ Summer ☐ Fall ☐ Winter

DENTAL HISTORY:

Please check all that apply:

☐ Silver mercury fillings How many? _____ ☐ Gold fillings ☐ Root canals

☐ Implants ☐ Tooth pain ☐ Bleeding Gums ☐ Gingivitis ☐ Problems with chewing

Do you floss regularly? ☐ Yes ☐ No
Do you brush at least two times daily? ☐ Yes ☐ No

FAMILY HISTORY:

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Blood/Bleeding disorder												
Cancers (of what?)												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Thyroid												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis/Dementia/Parkinson's/ ALS or other Motor Neuron Diseases												
Auto Immune Diseases (such as lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma/COPD												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Fatigue												
Environmental Sensitivities												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												