Everhope Clinic PLLC
Naturopathic Medicine

We are asking for a lot of information and it may feel overwhelming. We do this so we can have a complete understanding of you and your health. When dealing with chronic illness, it's a detective hunt and one never knows where an obstacle to cure may be found. Take your time, over several days if necessary, but please complete this form thoroughly as the information provided will help us with your diagnosis and treatment. If at any point you run out of room, go to the last page where you will be able to enter any additional information. This information will become part of your confidential medical record and will not be shared unless you expressly authorize its release. Please fill in electronically only.

PATIENT PROFILE

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: ____ Sex: ____ F ____ M ____ Other: _____

Address: _____ City: _____ State: ____ Zip: _____

Email: _____ May we add you to our email list? ____ Yes ____ No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we leave confidential voicemail messages for you at any of the above numbers? ____ No ____ Yes
If yes, please indicate which ones: ____ Home ____ Work ____ Cell

Occupation: _____ Employer: _____

Domestic Status: ____ Single ____ Partnered ____ Married ____ Separated ____ Divorced ____ Widowed

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear of us?

____ Physician: Dr. _____ ____ Friend ____ Flyer ____ Internet Search

____ MANP "Find an ND" ____ ILADs ____ Other: _____

Very briefly, what brings you in to this first visit? _____

How ready are you to work on your health? ____ **Work? 1 2 3 4 5 6 7 8 9 10 Ready, willing and able!**

CURRENT HEALTH

Current Primary Care Physician? _____ Phone: _____

Clinic Name: _____ Date of Last Visit: _____

Address, City, State, Zip: _____

Height: _____ Current Wt: _____ lbs Wt one year ago: _____ lbs Max Wt: _____ Min Wt: _____

How do you describe your health in general? ____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor

In one word, what is your most basic feeling about your health (e.g. uncertain, stressed, resigned, angry, hopeless, hopeful, motivated, happy, or other): _____

When was the last time you remember feeling really great? Indicate year and location: _____

List your top four health concerns, in order of importance to you, the most important listed first. Details will be asked on the next pages.

1. _____
2. _____
3. _____
4. _____

For each of the above health concerns, please complete the following pages, one page per health concern.

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CONCERN 1

Concern: _____ When did it start? _____

Have you had the same/similar problem before? ____ No ____ Yes

Describe the cause(s) of this concern, if known or suspected: _____

_____

Does anything make your symptoms worse? _____

Does anything make your symptoms better? _____

What treatments have you tried? _____

Are your symptoms getting progressively worse? ____ No ____ Yes

Are your problems interfering with your: ____ Work ____ Daily routine ____ Sleep Other: _____

If painful, characterize: ____Ache ____ Dull ____ Sharp ____ Radiating ____ Constant ____ Intermittent

Please indicate the severity of the pain on most days: ____ **Minor 1 2 3 4 5 6 7 8 9 10 Severe**

Have you previously received treatment for this condition? ____ No ____ Yes If yes, please answer the next set of questions:

Who has been the **primary** treating physician and clinic/hospital? If it was your Primary Care Physician, write "PCP": _____

What tests were run, including x-rays, CTs, MRI? _____

Test Results: _____

Diagnosis: _____

Treatment: _____

Treatment Results? ____ Good ____ Fair ____ Poor

Please list other physicians you have seen for this condition. ____ None

	Date	Physician	Clinic	City, State	Testing/Treatment
1.					
2.					
3.					
4.					

Additional remarks about any treatments: _____

_____

_____

_____

_____

_____

_____

_____

CONCERN 2

Concern: _____ When did it start? _____

Have you had the same/similar problem before? ____ No ____ Yes

Describe the cause(s) of this concern, if known or suspected: _____

_____

Does anything make your symptoms worse? _____

Does anything make your symptoms better? _____

What treatments have you tried? _____

Are your symptoms getting progressively worse? ____ No ____ Yes

Are your problems interfering with your: ____ Work ____ Daily routine ____ Sleep Other: _____

If painful, characterize: ____Ache ____ Dull ____ Sharp ____ Radiating ____ Constant ____ Intermittent

Please indicate the severity of the pain on most days: ____ **Minor 1 2 3 4 5 6 7 8 9 10 Severe**

Have you previously received treatment for this condition? ____ No ____ Yes If yes, please answer the next set of questions:

Who has been the **primary** treating physician and clinic/hospital? If it was your Primary Care Physician, write "PCP": _____

What tests were run, including x-rays, CTs, MRI? _____

Test Results: _____

Diagnosis: _____

Treatment: _____

Treatment Results? ____ Good ____ Fair ____ Poor

Please list other physicians you have seen for this condition. ____ None

	Date	Physician	Clinic	City, State	Testing/Treatment
1.					
2.					
3.					
4.					

Additional remarks about any treatments: _____

_____

_____

_____

_____

_____

_____

_____

CONCERN 3

Concern: _____ When did it start? _____

Have you had the same/similar problem before? ____ No ____ Yes

Describe the cause(s) of this concern, if known or suspected: _____

_____

Does anything make your symptoms worse? _____

Does anything make your symptoms better? _____

What treatments have you tried? _____

Are your symptoms getting progressively worse? ____ No ____ Yes

Are your problems interfering with your: ____ Work ____ Daily routine ____ Sleep Other: _____

If painful, characterize: ____Ache ____ Dull ____ Sharp ____ Radiating ____ Constant ____ Intermittent

Please indicate the severity of the pain on most days: ____ **Minor 1 2 3 4 5 6 7 8 9 10 Severe**

Have you previously received treatment for this condition? ____ No ____ Yes If yes, please answer the next set of questions:

Who has been the **primary** treating physician and clinic/hospital? If it was your Primary Care Physician, write "PCP": _____

What tests were run, including x-rays, CTs, MRI? _____

Test Results: _____

Diagnosis: _____

Treatment: _____

Treatment Results? ____ Good ____ Fair ____ Poor

Please list other physicians you have seen for this condition. ____ None

	Date	Physician	Clinic	City, State	Testing/Treatment
1.					
2.					
3.					
4.					

Additional remarks about any treatments: _____

_____

_____

_____

_____

_____

_____

_____

CONCERN 4

Concern: _____ When did it start? _____

Have you had the same/similar problem before? ____ No ____ Yes

Describe the cause(s) of this concern, if known or suspected: _____

_____

Does anything make your symptoms worse? _____

Does anything make your symptoms better? _____

What treatments have you tried? _____

Are your symptoms getting progressively worse? ____ No ____ Yes

Are your problems interfering with your: ____ Work ____ Daily routine ____ Sleep Other: _____

If painful, characterize: ____Ache ____ Dull ____ Sharp ____ Radiating ____ Constant ____ Intermittent

Please indicate the severity of the pain on most days: ____ **Minor 1 2 3 4 5 6 7 8 9 10 Severe**

Have you previously received treatment for this condition? ____ No ____ Yes If yes, please answer the next set of questions:

Who has been the **primary** treating physician and clinic/hospital? If it was your Primary Care Physician, write "PCP": _____

What tests were run, including x-rays, CTs, MRI? _____

Test Results: _____

Diagnosis: _____

Treatment: _____

Treatment Results? ____ Good ____ Fair ____ Poor

Please list other physicians you have seen for this condition. ____ None

	Date	Physician	Clinic	City, State	Testing/Treatment
1.					
2.					
3.					
4.					

Additional remarks about any treatments: _____

_____

_____

_____

_____

_____

_____

_____

OTHER CURRENT MEDICAL CONDITIONS

Do you have any other health problems for which you are not seeing us? ____ No ____ Yes If yes, please list them:

	Condition	Onset	Treating Physician	Clinic
1.				
2.				
3.				
4.				
5.				

HEALTH MAINTENANCE

Indicate the most recent date and result. Please bring any test results with you to your appointment. (F= female, M=male)

Physical Exam: _____ Dental Exam: _____

Eye Exam: _____ Chest X-ray: _____

Prostate Exam (M): _____ DEXA Scan (F, 60+): _____

Colonoscopy/Sigmoidoscopy (50+):_____ Fecal Occult Blood: _____

Vitamin D: _____ HIV Test: _____

EKG: _____ Blood Work: _____

Genetic Testing: _____ Other: _____

Other: _____ Other: _____

Other: _____ Other: _____

PAST MEDICAL HISTORY

Early Health History

Did your mother have any problems during her pregnancy with you such as illness, stress, use of alcohol, tobacco or recreational drugs, took medications, or had a traumatic delivery? ____ No ____ Yes If yes, please explain: _____

_____

Were you born via Caesarean Section? ____ No ____ Yes

Were you breast fed as an infant? ____ No ____ Yes If yes, for how long? _____

During childhood and adolescence, was your home-life loving and supportive or were there significant stresses?

____ Loving ____ Stressful If stressful, please explain: _____

_____

Please indicate if you had any of the following illnesses as a child:

____ Eczema	____ Recurrent colds	____ Meningitis
____ Asthma	____ Bronchitis	____ Frequent earaches
____ Chronic runny nose	____ Pneumonia	____ Other (specify): _____

Were you ever on frequent or prolonged antibiotics? ____ No ____ Yes Please specify: _____

Did you receive standard immunizations? ____ No ____ Yes Were you on a delayed schedule? ____ No ____ Yes

Did you experience any adverse reactions to the immunizations? ____ No ____ Yes If yes, please explain in as much detail as you know: _____

Did you ever have a concussion as a child? ____ No ____ Yes If yes, please explain: _____

_____

Please list any other childhood illnesses you had that were not listed above.

	Illness	Age		Illness	Age
1.	_____	____	6.	_____	____
2.	_____	____	7.	_____	____
3.	_____	____	8.	_____	____
4.	_____	____	9.	_____	____
5.	_____	____	10.	_____	____

Adult Health History

Please list major illnesses you have experienced as an adult that have not already been mentioned above.

	Illness	Age		Illness	Age
1.	_____	____	6.	_____	____
2.	_____	____	7.	_____	____
3.	_____	____	8.	_____	____
4.	_____	____	9.	_____	____
5.	_____	____	10.	_____	____

Do you receive a regular flu vaccination? ____ No ____ Yes

List any other vaccines you have received as an adult. _____

List any negative side affects you have experienced from vaccines. _____

Have you ever have a concussion as an adult? ____ No ____ Yes If yes, please explain: _____
_____

Do you have any implants (breast, stents, artificial hip, dental, etc.)? ____ No ____ Yes If yes, please explain including material type: _____

Major Injuries

Please include auto accidents, sports injuries, and other injuries not already mentioned above.

	Injury	Date	Outcome
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Hospitalizations

	Reason	Date	Outcome
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Surgeries

	Type	Reason	Date	Outcome
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Chemotherapy/Radiation Treatments

Have you ever had chemotherapy? ____ No ____ Yes If yes, is the treatment complete? ____ No ____ Yes.

Please specify the chemotherapy agent(s) and when you had your last treatment:

	Chemotherapy Agent	Last Treatment
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Have you ever received radiation therapy? ____ No ____ Yes If yes, is the treatment complete? ____ No ____ Yes

Please specify the kind of radiation received and when you had your last treatment:

	Radiation Agent	Last Treatment
1.	_____	_____
2.	_____	_____

Emotional Traumas

Have you ever been physically, emotionally, or verbally abused? ____ No ____ Yes

Have you ever been touched without your permission in a way that made you feel uncomfortable? ____ No ____ Yes

Do you have any concerns about violence in your life now? ____ No ____ Yes

If you answered yes to any of the above questions, please explain: _____
_____

FEMALE HEALTH HISTORY

Age at first period? _____ Are you in menopause? ____ No ____ Yes

On what date did your last period begin? _____ Are/were your periods regular? ____ No ____ Yes

Periods last(ed) _____ days and occur(red) every _____ days. Is/was heavy bleeding a problem? ____ No ____ Yes

Do/did you have premenstrual syndrome? ____ No ____ Yes If yes, please describe: _____
_____

Do/did you experience significant menstrual cramping? ____ No ____ Yes

Date of last Pap smear: _____ Results: _____

Have you ever had an abnormal Pap? ____ No ____ Yes If yes, please explain: _____

Do you have excessive, unwanted hair growth or unexplained loss of hair? ____ No ____ Yes

If yes, please explain including location: _____

Do you have a history of endometriosis? ____ No ____ Yes Do you have a history of infertility? ____ No ____ Yes

Describe any current menstrual or menopausal symptoms or concerns: _____

Have you ever been pregnant? ____ No ____ Yes If no, skip this set of questions.

Are you currently pregnant? ____ No ____ Yes If yes, how far along? ____ months
Age at first pregnancy? _____ Age at last pregnancy? _____ Number of pregnancies? _____
Number of living children? _____ Number of stillbirths? _____
Number of miscarriages? _____ When in pregnancy did this occur? _____
Did you breast feed? ____ No ____ Yes For how long? _____

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REVIEW OF SYSTEMS

Indicate with a C any conditions you currently have or a P for conditions you've had in the past that have since resolved.

	Constitutional		Mental		Neurological		Integumentary
	Fatigue / Tiredness		Anxiety		Dizziness		Skin Rash / Itching
	Fever		Depression		Fainting		Skin Infections
	Night Sweats		Brain Fog		Recurrent Headaches		Growths
	Poor Sleep		Forgetfulness		Migraines		Mole Change
			Mood Swings		Numbness		Nail Problems
			Anger Outbursts		Weakness		Recent Hair Loss
			Other:		Tingling Sensation		

	Endocrine		Immune System		Ear and Eye		Respiratory
	Thyroid Disorder		Cancer		Hearing Loss		Freq. Sore Throats
	Diabetes		Autoimmune		Ringing in Ear(s)		Freq. Sinus Infections
	Other: _____		Allergies		Earache		Asthma
	Other: _____		Hay Fever		Dizziness (faint)		Difficulty Breathing
			Enlarged Lymph Node		Vertigo (room spins)		Shortness of Breath
			Frequent Colds / Flu		Recent Vision Change		Chronic Bronchitis
					Eye Pain		Chronic Cough
					Dry Eyes		Tuberculosis
					Double Vision		Pneumonia (bacterial)
							Pneumonia (viral)
							Chest Pain

	Gastrointestinal		Cardiology / Hematology		Genitourinary		Gynecological
	Stomach Ulcers		Chest Pain		Kidney Failure		PMS
	Acid Reflux		Heart Disease		Kidney Infection		Menstrual Cramps
	Gas and Bloating		Heart Failure		Kidney Stones		Heavy Menstrual Flow
	Constipation		Stroke		Bladder Infection		Irregular Cycles
	Diarrhea (infectious)		Irregular Heartbeat		STD - Chlamydia		Menopause
	Diarrhea (bloody)		Hemorrhoids-external		STD - HIV		Hot Flashes
	Blood in Stools		Hemorrhoids-internal		STD - HPV		Vaginal Discharge
	Persistent Nausea		Frequent Nose Bleeds		STD - Syphilis		Breast Discharge
	Recurrent Vomiting		Varicose Veins		STD - Other		Dense Breasts
	Liver Disease		Poor Circulation		Prostate Enlargement		Other Breast Issues
	Hepatitis		Anemia		Erectile Dysfunction		
	Abdominal Pain		Blood Diseases		Loss of Libido		
			Easy Bruising				

	Musculoskeletal		Metabolic		Other (write-in)
	Arthritis		Loss of Appetite		
	Back Pain		Weight Gain		
	Joint Pain		Weight Loss		
	Stiffness		Weight redistribution		
	Bursitis				
	Fibromyalgia				

Medication	Dosage and Frequency (mcg, mg, ml, units, drops)	Route (Oral, sublingual, injection, IV, rectally, vaginally)	Prescribed by (Doctor's name or Self)	Purpose and Date Started
Prescription Medications				
Supplements, Vitamins, Herbals				
Homeopathics				

Have you experienced any intolerances or allergic reactions to any medications or supplements or had to lower the dose due to being too sensitive to a normal dose? ____ No ____ Yes

If yes, please list the medication or supplement and describe the reactions you experienced.

Medication/Supplement Reaction

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

LIFESTYLE

Stress

Please check the stressors you have experienced in the past year.

____ Change in Job
____ Retirement
____ New Baby
____ Change in Marital Status
____ Other, please specify: _____

____ Family Stress
____ Major Personal Injury or Illness
____ Financial Concerns
____ Abusive Relationship

On a scale of 1 to 10, 1 being minor and 10 the worse you can imagine, how would you rate your current stress? ____

What do you do to relax or reduce stress? _____

Employment

Please describe your occupation: _____

How satisfied are you with your job? ____ Completely ____ Very ____ Satisfied ____ Somewhat ____ Not at All

What hours/days do you typically work? _____

Do you work a swing shift, nights, or irregular hours? ____ No ____ Yes If yes, please describe: _____

Vacations

Do you take vacations? ____ No ____ Yes If yes, how many per year? ____

Do you find your vacations refreshing or additional work? ____ Refreshing ____ Additional Work

Sleep

Time you go to sleep: _____ Time you awaken: _____ Time you get out of bed: _____

What is the quality of your sleep? ____ Wake well rested ____ Wake tired ____ Sleep does not refresh me

Do you wake at night? ____ No ____ Yes If yes, how many times? ____

What causes you to wake up? _____

Do you have trouble falling back to sleep? ____ No ____ Yes ____ Sometimes

Do you sleep in total darkness? ____ No ____ Yes If no, indicate source of light: _____

Do you use an electric blanket? ____No ____ Yes

Do you sleep on a memory foam mattress? ____ No ____ Yes Do you sleep on a waterbed? ____ No ____ Yes

Do you take naps during the day: ____ No ____ Yes ____ No, but I would like to

If yes, at what time? _____ For how long? _____ minutes

If you would like to take a nap but don't, at what time do you have this feeling? _____

Hobbies/Activities for Pleasure

What hobbies and activities do you engage in for pleasure? (Do not include exercise here.)

Activity	Times/week	Times/month
_____	____	____
_____	____	____
_____	____	____
_____	____	____

Exercise

Do you exercise? ____ No ____ Yes

If yes, please indicate what you do, for how long, and how many days per week:

Activity	Minutes/session	Days/week
_____	____	____
_____	____	____
_____	____	____
_____	____	____
_____	____	____

Please list any other exercises you enjoy but are not currently participating in: _____
_____

Diet

Do you follow a particular diet? ____ No ____ Yes If yes, what do you call it? _____

Do you avoid any foods? ____ No ____ Yes If yes, which ones? _____

Do you crave any foods? ____ No ____ Yes If yes, which ones? _____

How often do you eat out? ____ /week How often do you eat fast food? ____ /week

Do/have you ever had an eating disorder? ____ No ____ Yes If yes, please describe: _____

Please describe what you typically eat for the following meals. If you don't have a typical meal, please describe your last meal. Include beverages.

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Dessert: _____

Who does the grocery shopping for you? _____ Where are groceries purchased? _____

Who cooks for you? _____ Do you eat organically at least some of the time? ____ No ____ Yes

Do you heat food in a microwave? ____ No ____ Yes Do you use plastic in the microwave? ____ No ____ Yes

How much water do you drink per day? ____ ounces (Note: a one cup measuring cup is 8 ounces.)

Is your water filtered? ____ No ____ Yes If yes, type of filter used: _____

Urinary Function

How many times per day on average do you urinate? ____ Do you strain in order to pass urine? ____ No ____ Yes

Do you have difficulties starting or stopping your urine flow? ____ No ____ Yes

Is there any blood in your urine? ____ No ____ Yes Is there any sediment in your urine? ____ No ____ Yes

Do you experience loss of bladder control or leakage? ____ No ____ Yes If yes, does it happen when you feel you have an urgent need to urinate or does it happen when a stress is applied to the bladder such as coughing or sneezing?

____ Urgency ____ Stress How often? ____ /week

Do you experience pain with urination? ____ No ____ Yes If yes, how often? ____ /week

Digestive Function

Do you have any known food/beverage allergies, sensitivities, or intolerances? ____ No ____ Yes
If yes, please specify the food(s) and the reaction(s) below. Common problem foods are dairy, wheat, gluten, corn, sugar, eggs, citrus, coffee, alcohol, fatty foods, salty foods, spicy foods, and meat, although your sensitivities may be different. Common reactions include stuffy nose, heartburn, bloating, diarrhea, sleepiness, difficulty with concentration, hives, rashes, shortness of breath, wheezing, anaphylaxis, etc.

Food/Drink	Symptom(s)	How often do you consume these foods? Never	Less than 1/wk	Daily	More than 1/day
_____	_____	____	____	____	____
_____	_____	____	____	____	____
_____	_____	____	____	____	____
_____	_____	____	____	____	____
_____	_____	____	____	____	____

Please list any foods/beverages that you crave or that help you to feel better.

Food/Drink	Any symptom(s) with consumption?	How often do you consume these foods? Never	Less than 1/wk	Daily	More than 1/day
_____	_____	____	____	____	____
_____	_____	____	____	____	____
_____	_____	____	____	____	____

Describe any other digestion problems you have: _____

How many bowel movements do you have each day? ____ /day. If less than 1 per day, how many per week? ____ /wk

Do you usually have to strain to have a bowel movement? ____ No ____ Yes

Have you ever had blood with bowel movements? ____ No ____ Yes

If yes, was the cause determined and if so what was the cause? ____ No ____ Yes, _____

Do you see blood on the toilet paper? ____ No ____ Yes

Are your stools ever black or tarry? ____ No ____ Yes

What type of bowel movement do you have most often? ____

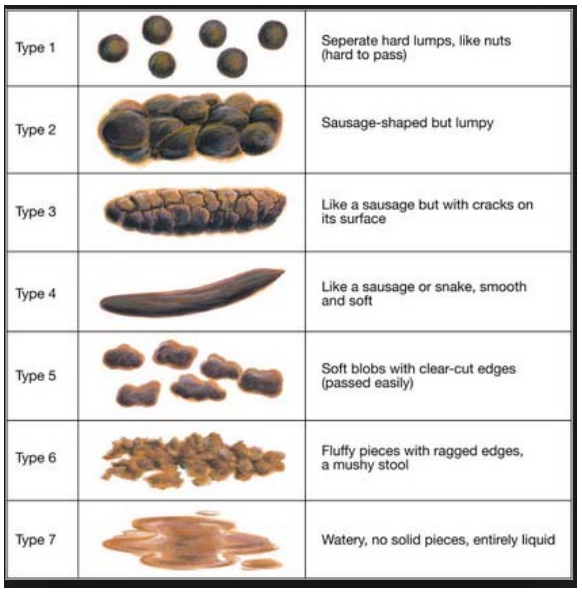
Do you experience another type of bowel movement on a regular basis? ____ No ____ Yes If yes, please indicate type. ____

Have you noticed that your bowel movement types are related to what you eat, how you are feeling, etc. or have your bowel habits changed recently? ____ No ____ Yes

If yes, please explain: _____
_____
_____

When was the last time your received antibiotics? _____

Did you take probiotics at that time? ____ No ____ Yes



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HEALTH RISKS

Please be honest in this section. It is not about judgement, but about determining what we can do to best help you on your healing journey.

Tobacco

Do you currently or did you ever use tobacco products? ____ No ____ Yes

			Age Started	Age Stopped
If yes, what do you use and how often?	Cigarettes	____/day	_____	_____
	E-cigs	____/day	_____	_____
	Cigars	____/day	_____	_____
	Pipe	____/day	_____	_____
	Smokeless	____/day	_____	_____

Are there other smokers in the household? ____ No ____ Yes Do they smoke inside? ____ No ____ Yes

Alcohol

Do you consume alcoholic beverages? _____ No ____ Yes

If yes, please indicate type and how much:

Beer	____ 12 oz can/wk
Wine	____ 5 oz glass/wk
Hard Alcohol	____ 1.5 oz/wk
Other	____/wk, specify: _____

List any symptoms you have from drinking: _____

Caffeine

Do you consume caffeinated beverages? ____ No ____ Yes

If yes, please indicate type and how much:

Coffee	____ oz/day
Black Tea	____ oz/day
Soda	____ oz/day
Type of soda:	_____

Name	Measurement
Demi	3 US fl oz (89 mL)
Short	8 US fl oz (240 mL)
Tall	12 US fl oz (350 mL)
Grande	16 US fl oz (470 mL)
Venti	20 US fl oz (590 mL), 26 US fl oz (770 mL)
Trenta	31 US fl oz (920 mL)

List any symptoms you have from caffeine: _____

Do you avoid caffeine in the afternoon or altogether because it can keep you up all night? ____ No ____ Yes

Recreational Drugs

Do you use recreational drugs? ____ No ____ Yes

If yes, please indicate type and how often:

Marijuana	____/wk
Cocaine	____/wk
Crack	____/wk
Amphetamine	____/wk
Injectable	____/wk, specify: _____
Other	____/wk, specify: _____

Tattoos

Do you have tattoos? ____ No ____ Yes If yes, do any have colored ink? ____ No ____ Yes

If you have tattoos, how many do you have and where are they located? _____

_____

Have you noticed any swollen lymph nodes? ____ No ____ Yes If yes, where? _____

Sexual Activity

Are you currently sexually active? ____ No ____ Yes

Sexually active with? ____Men ____ Women ____ Both

Do you practice safer sex? ____ No ____ Yes ____ Sometimes

If yes, what type of protection do you use? _____

Do you have a need for birth control? ____ No ____ Yes If yes, what method of birth control is currently used and how frequently is it used? _____

Have you ever had sexual difficulties? ____ No ____ Yes If yes, please describe: _____
_____

Have you ever had a sexually transmitted disease? ____ No ____ Yes If yes, please indicate type(s):

____ Chlamydia ____ Gonorrhea ____ Herpes ____ Syphilis ____ HIV/AIDS

____ Genital Warts ____ Other: _____

If sexually active, is your present sex life satisfactory? ____ No ____ Yes If no, please describe: _____

_____

(Continued on next page.)

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FAMILY HEALTH HISTORY

Please indicate which of the following health problems your family (mother, father, siblings, children, or grandparents) has experienced. If it is a current condition, enter the letter C in the column next to the condition. Use the letter P to indicate a past problem that has resolved. Where there is an underline in the Condition column, please indicate type of condition. For the "other" columns, after the C or P, write in the family relationship ("brother", "sister", "grandmother", etc.) and their current age or age at death. If deceased, add the letter D after the age.

Condition **Current Age/Age at Death**	**Father** _____	**Mother** _____	**Other – Who and Age**	**Other – Who and Age**	**Other – Who and Age**
Alzheimer's					
Allergies/Hay Fever					
Asthma					
Anemia					
Arthritis _____					
Autoimmune _____					
Cancer _____					
Cancer _____					
Cancer _____					
Diabetes					
Digestive Problems					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Liver Disease					
Lung Disease					
Lyme Disease					
Mental Illness					
Migraine					
Mood Disorder _____					
Obesity					
Osteoporosis					
Stroke					
Substance Abuse					
Thyroid Disorder					
Ulcer					
Other _____					
Other _____					

ENVIRONMENTAL EXPOSURES

List all the locations in which you have lived by city, state and country if not in the US.

_____ _____
_____ _____
_____ _____
_____ _____

Community

For each item listed:	Did/do you live nearby?		When, where and how long?
Heavy traffic	____ No	____ Yes	_____
Vehicle idling area	____ No	____ Yes	_____
Landfill	____ No	____ Yes	_____
Farm(s)	____ No	____ Yes	_____
Industrial plants	____ No	____ Yes	_____
Radiation source	____ No	____ Yes	_____
Mine	____ No	____ Yes	_____
Polluted waters	____ No	____ Yes	_____
Golf course	____ No	____ Yes	_____
Gas station	____ No	____ Yes	_____
Dry cleaner	____ No	____ Yes	_____
Major power lines	____ No	____ Yes	_____
Other hazards	____ No	____ Yes	_____

Home

How long have you lived in your present residence? ____ years

Type of residence: ____ House ____ Mobile home ____ Apartment ____ Other (specify): _____

For apartments, indicate location within the building: ____ Basement ____ Over store Floor number: ____

How old is the residence? ____ years If built before 1978, do you have:

Asbestos insulation	____ No	____ Yes
Vinyl tile	____ No	____ Yes
Flaking paint	____ No	____ Yes

Type of heating fuel:

____ Natural gas ____ Propane ____ Oil ____ Electric ____ Wood

When was the last time the filter was changed? _____ Frequency of changes? ____ per year

When were your air ducts last cleaned? _____

Does your home have air conditioning? ____ No ____ Yes If yes, indicate type: ____ Central ____ Window

When was the last time the filter was changed? _____ Frequency of changes? ____ per year

Do you have a gas stove? ____ No ____ Yes If yes, do you use a every vent time? ____ No ____ Yes

Water source for bathing: ____ City ____ Well ____ Other (specify) _____

Do you have carbon monoxide detectors? ____ No ____ Yes

Have you done any painting, renovating or purchased new large furniture in the past two years? ____ No ____ Yes

If yes, please indicate when and what, including types of materials used: _____

_____

_____

Think of all the places you have lived. Indicate if any of the following are/were present in the home.

	Current Home		Former Home (indicate dates)
Damp, musty basement or crawl space	____No	____ Yes	_____
Condensation on windows or outside closet walls	____No	____ Yes	_____
Water leaks that were not *immediately* repaired	____No	____ Yes	_____
Visible mold (specify location) _____	____No	____ Yes	_____
Stagnant, stuffy air	____No	____ Yes	_____
Gas appliances: ____ water heater ____ furnace	____No	____ Yes	_____
Wood stove or fireplace	____No	____ Yes	_____
Air cleaner (specify) _____	____No	____ Yes	_____
Carpets (age/location) _____	____No	____ Yes	_____
Copy/fax/printer	____No	____ Yes	_____
Pets (specify) _____	____No	____ Yes	_____
Do you use flea collars on your pets?	____No	____ Yes	_____
Indoor plants	____No	____ Yes	_____
Do you use pesticides on your plants?	____No	____ Yes	_____

Do you use dust mite covers? ____ No ____ Yes (specify) ____ Pillow covers ____ Mattress covers

Do you use a: ____ Central vacuum ____ HEPA filter vacuum ____ Vacuum with a dust meter

List by brand name any cleaners used in your home.

Bathroom cleaners: _____
Floor cleaners: _____
Window/mirror cleaners: _____
Oven cleaners: _____
Deodorizers: _____
Laundry detergent: _____
Fabric softener: _____
Other (specify): _____

Do you:

Use mothballs? ____ No ____ Yes
Use potpourri, spray air fresheners, or wall plug-ins? ____ No ____ Yes
Burn candles? ____ No ____ Yes
Get your clothing dry cleaned? ____ No ____ Yes
Require shoes to be removed at the door? ____ No ____ Yes

Have you ever had to change your residence due to health reasons? ____ No ____ Yes

If yes, please explain: _____

Personal

Do you eat fish? ____ No ____ Yes If yes, on average, how many 3-4 oz servings do you have per week? ____
Indicate, in order of frequency, the types of fish you consume: _____

Are you sensitive to any of the following?

Odors: ____ No ____ Yes (specify) _____
Smoke: ____ No ____ Yes (specify) _____
Soap: ____ No ____ Yes (specify) _____
Fumes: ____ No ____ Yes (specify) _____
Perfume: ____ No ____ Yes (specify) _____
Others: ____ No ____ Yes (specify) _____

Do you have seasonal allergies and if so, how would you rate your reaction?

Dust:	____ No	____ Yes	____ Mild	____ Moderate	____ Severe
Insect bites/stings:	____ No	____ Yes	____ Mild	____ Moderate	____ Severe
Grasses:	____ No	____ Yes	____ Mild	____ Moderate	____ Severe
Trees:	____ No	____ Yes	____ Mild	____ Moderate	____ Severe
Ragweed:	____ No	____ Yes	____ Mild	____ Moderate	____ Severe
Pet Dander:	____ No	____ Yes	____ Mild	____ Moderate	____ Severe
Mold:	____ No	____ Yes	____ Mild	____ Moderate	____ Severe
Other: specify: _____	____ No	____ Yes	____ Mild	____ Moderate	____ Severe
Other: specify: _____	____ No	____ Yes	____ Mild	____ Moderate	____ Severe

Do you:

Use nail polish?	____ No	____ Yes	If yes, how often? _____
Get regular manicures?	____ No	____ Yes	If yes, how often? _____
Have acrylic fingernails?	____ No	____ Yes	

Do you feel worse in libraries, used book stores, or consignment shops? ____ No ____ Yes

How often are you exposed to scented personal care products?

	Soap	Lotion	Cosmetics	Hair Coloring	Hair Perms	Perfume/ Aftershave	Other
Never	____	____	____	____	____	____	____
Less than 1/wk	____	____	____	____	____	____	____
Daily	____	____	____	____	____	____	____

Have you ever noticed that you react to chemicals that don't seem to bother most people? Reacting means that you get worse within 48 hours of exposure or you get better when you are removed from the exposure. Exposure includes being near, touching, smelling, breathing, eating, drinking, swallowing, or injecting something.

Chemical	Symptom(s)	Presently Affected 1 = a little 2 = somewhat 3 = a lot	Affected in the Past
_____	_____	____	____
_____	_____	____	____
_____	_____	____	____
_____	_____	____	____
_____	_____	____	____

Dental

Do you have amalgams (silver/mercury fillings)? ____ No ____ Yes If yes, how many? ____

Have you ever had silver/mercury fillings removed? ____ No ____ Yes

If yes, how many and when? _____

Do you have gold fillings? ____ No ____ Yes If yes, how many? ____

Do you have any implants? ____ No ____ Yes If yes, for how long and of what material? _____

Do you have any root canals? ____ No ____ Yes If yes, how many and which teeth? _____

Do you experience itchy skin, chronic congestion, headache, and/or GI problems after consuming any of the following: alcohol, sauerkraut or other fermented foods, aged cheese, smoked meat, shellfish, beans and pulses, nuts, chocolate, vinegar, citrus fruit, tomatoes, wheat germ, additives such as sulphites, nitrates, glutamate, food dyes, tea, or energy drinks? ____ No ____ Yes If yes, list the foods and the reaction they cause: _____

_____

_____

Occupation and Hobbies

Please list chemicals, solvents, heavy metals, paints, dusts, fibers, fumes, radiation, biologic agents (mold, bacterial, viruses), and physical agents (extreme heat, extreme cold, vibration, and noise) to which you have had exposure. Be sure to include both occupations (including a household member bringing chemicals home on clothing) and hobbies you or others in the home may be doing such as furniture refinishing, home renovations, art projects (painting, ceramics, stained glass, leather work, etc.), gardening (pesticide use), etc. Protective measures and equipment includes showering at work, laundering clothes at work, use of gloves, apron, mask, respirator, hearing protection, etc.

Past/Present Job or Hobby	For how long? (yrs)	Exposures	Protective measures/equipment
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Please answer these questions with respect to your current or most recent work environment.

Age of building: ____ years Number of floors: ____ Number of occupants: ~_____

Neighborhood: ____ Rural ____ Commercial ____ Industrial

Indicate which of the following does/did your work environment have?

____ Laboratory
____ Cafeteria
____ Windows that don't open
____ Banks of computers
____ Manufacturing area
____ Central air conditioning
____ Unvented smoking areas
____ Partitions or room dividers
____ Unvented copy machines
____ Nearby parking garage
____ Carpeting, how old? ____ yrs

Have any of the following occurred in your work environment over the past 12 months?

____ Use of pesticides ____ inside ____ outside
____ Fire, smoke
____ New flooring, furniture, etc. (specify) _____
____ Painting
____ Chemical spill, leak (specify) _____
____ Flood, water leaks
____ Carpet cleaning
____ New construction or remodeling
____ Accidents (specify) _____
____ Stress (specify) _____

Have you ever had to change your type or place of employment due to health reasons? ____ No ____ Yes

If yes, please explain: _____

ADDITIONAL INFORMATION

Use this space to add any additional information. Please provide enough information to make clear what question you are answering.