

Midway Center for Integrative Medicine

August 14, 2010

NAME: _____

DATE: _____

Past History Surgeries:

Hospitalizations:

Major illnesses:

Major injuries:

Medication: 1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____ 9) _____

Supplements: 1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____ 9) _____

Family History- List all serious conditions e.g. age, at death, heart attacks, strokes, cancer (type), diabetes, other

Mother: age _____ alive? _____ serious illnesses:

Father: age _____ alive? _____ serious illnesses:

Serious illnesses experienced by brothers & sisters:

Social History Occupation: _____ **Occupation hazard exposure:** _____

Marital status: Single __ Married __ Divorced __ Widow __ **Children's ages** _____

Heterosexual __ **Homosexual** __

Aerobic activity e.g. walking - type, daily or weekly amounts:

Anaerobic exercise e.g. weights - type, daily or weekly amounts:

Meditation/prayer - frequency and length:

Alcohol - type, daily & weekly quantities:

Cigarettes (packs per day): _____ **Eat organic:** _____

Caffeinated coffee (quantity): _____ **Vegetarian:** _____

Caffeinated soft drinks (quantity): _____ **Vegan:** _____

Other soft drinks: _____ **# of non-potato vegetables daily:** _____

Illicit drugs (marijuana, others): _____ **# of fruits daily:** _____

Spiritual History: 0(never), 1(seldom), 2(sometimes), 3(often), 4(regularly), 5(daily)

____ Do you share your feelings?

____ Can you find someone to call for a favor?

____ Do you belong to a group or community?

____ Do you have the ability to forgive yourself and others?

____ Have you demonstrated the willingness to commit to a marriage or comparable long-term relationship?

____ Do you experience intimacy, besides sex, in your committed relationships?

____ Do you confide in or speak openly with one or more close friends?

____ Do you or did you feel close to your parents?

____ If you have experienced the loss of a loved one, have you fully grieved that loss?

____ Has your experience of pain enabled you to grow spiritually?

____ Do you go out of your way or give your time to help others?

____ Do you feel a sense of belonging to a group or community?

____ Do you experience unconditional love?

*****TURN OVER TO COMPLETE QUESTIONNAIRE*****

Symptoms

- | | | |
|--|---|--|
| <input type="checkbox"/> Brain fog (fuzzy headed) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Impaired concentration | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Forgetful | <input type="checkbox"/> Vision | <input type="checkbox"/> Dry eyes |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Taste | <input type="checkbox"/> Smell |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Cold intolerance |
| <input type="checkbox"/> obsessive thoughts | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Bloating | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bloody bowel movement | <input type="checkbox"/> Black tarry bowel movement | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Nighttime urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Pain in calves with exercise | |
| <input type="checkbox"/> Change in moles | <input type="checkbox"/> Skin problem | <input type="checkbox"/> Muscles aches |
| <input type="checkbox"/> Nighttime leg cramps | <input type="checkbox"/> Restless legs in bed | <input type="checkbox"/> Bowel movement daily? |
| <input type="checkbox"/> Snore | <input type="checkbox"/> Daytime drowsiness | <input type="checkbox"/> Dream recall? |
| <input type="checkbox"/> Sensitive to odors, perfume | | |

In the last ten years have you had any of the following:

- 'Silver' mercury fillings Eaten tunafish weekly Metal exposure work/hobby
 Lived next to major highway Cigarette smoke exposure Grew up in old house
 Exposed to car exhaust or gasoline fumes Eaten fish 3 or more times a week
 Lived in a city where the air was polluted Coal dust or mercury exposure
 Grew up exposed to car exhaust or gasoline fumes Eat packaged snack foods
- Year of last colonoscopy Year of last bone density scan
 Year of last cholesterol levels Year of last blood sugar check
 Year of last complete physical exam Year of last eye exam
 Last pap smear (mo/year) Last mammogram - thermogram (mo/year)

Women: menopausal? last menstrual period(mo/yr) menstrual cramps
 heavy periods low sexual interest irregular periods sore breasts
 premenstrual irritability, anxiety, sadness, swelling, migraine, or insomnia
 vaginal dryness hot flashes night sweats

Men: Date of last prostate blood test (PSA)

- | | | |
|--|---|---|
| <input type="checkbox"/> low sexual interest | <input type="checkbox"/> poor sex performance | <input type="checkbox"/> loss of drive |
| <input type="checkbox"/> nighttime anxiety | <input type="checkbox"/> night sweats | <input type="checkbox"/> loss of confidence |
| <input type="checkbox"/> loss of strength | <input type="checkbox"/> discharge from penis | <input type="checkbox"/> curved penis |

Would you like to schedule a complete physical exam?

Would you like an appointment to discuss optimizing quality of life/life expectancy?

Do you prefer to use natural approaches instead of prescription medicine?

Would you like to discuss alternatives to your current medicine?