Patient History

Name _____ Date _____

Address _____ Home phone _____

Work phone _____ Date of birth ___/___/_____ Profession _____

No. of children _____

Please give the main reasons for your request for consultation: _____

_____

How were you referred? _____

Name and address of your primary care physician:

_____

Please complete the following personal past history questionnaire with regard to illnesses, surgery, and medications.

Between 0 and 1 year of age:

Birth weight: _____ Diseases: _____

Surgical operations: _____

Age of first tooth? _____ start to walk? _____ start to talk? _____

Between 1 and 10 years of age:

Infections: ___ nose ___ throat ___ ear ___ sinusitis ___ tonsillitis ___ bronchitis

___pneumonia ___ other

Use of antibiotics? _____

Tonsils removed? ___ yes Polyps removed? ___ yes When? _____

Other surgical operations? _____

Physical development? Growth? ___ slow ___ normal ___ fast

School results? _____

Condition of teeth? _____

Between 10 and 20 years of age:

Infections: nose-throat-ear? _____ Lungs? _____

Did you suffer from rheumatism? _____ Mononucleosis? _____ Jaundice? _____

For women: at what age did you begin menstruating? _____

Physical development? _____

Did you have any weight problems in those years? _____

How was your overall health? _____ Condition of teeth? _____

Military service? _____

School or college results? _____

Between 20 and 30 years of age:

Infections? _____ Which ones? _____ Mononucleosis? _____

Surgical operations? _____ Accidents? _____

Complaints in this period? _____

Overall health in this period? _____

Treatments? _____ Teeth condition? _____

Military service? _____ Gums-condition? _____

Between 30 and 40 years of age:

Infections? _____ Which ones? _____ Mononucleosis? _____

Surgical operations? _____ Accidents? _____

Complaints in this period? _____

Overall health in this period? _____

Treatments? _____ Teeth? _____ Gums? _____

Between 40 and 50 years of age:

Infections? _____ Which ones? _____ Mononucleosis? _____

Surgical operations? _____ Accidents? _____

Complaints in this period? _____

Overall health in this period? _____

Treatments? _____ Teeth? _____ Gums? _____

50 years and over:

Infections? _____ Which ones? _____ Mononucleosis? _____

Surgical operations? _____ Accidents? _____

Complaints in this period? _____

Overall health in this period? _____

Treatments? _____ Teeth? _____ Gums? _____

In your family (grand-parents, parents, brothers, sisters, brothers and sisters of your parents, your children), please indicate any family member who suffers from the following (If yes, please indicate his or her relationship to you):

Obesity:	___ yes Who? _____	Thinness:	___ yes Who? _____
Depression:	___ yes Who? _____	Epilepsy:	___ yes Who? _____
Migraines:	___ yes Who? _____	Eczema:	___ yes Who? _____

Psoriasis:	___ yes Who? _____	Acne:	___ yes Who? _____
Emphysema:	___ yes Who? _____	Chronic bronchitis:	___ yes Who? _____
Tuberculosis (lung):	___ yes Who? _____	Bedwetting:	___ yes Who? _____
Allergies:	___ yes Who? _____	Goiter:	___ yes Who? _____
High blood pressure:	___ yes Who? _____	Low blood pressure:	___ yes Who? _____
Rheumatism:	___ yes Who? _____	Gout:	___ yes Who? _____
Heart attack :	___ yes Who? _____	Arteriosclerosis (legs):	___ yes Who? _____
Stomach ulcer:	___ yes Who? _____	Gallstones:	___ yes Who? _____
Juvenile diabetes:	___ yes Who? _____	Maturity onset diabetes:	___ yes Who? _____

Precocious puberty (before age 12): ___ yes Who? _____

Late puberty (after age 15): ___ yes Who? _____

Is your husband/wife/partner suffering or has he (she) suffered from one or more of the above mentioned conditions? ___ yes ___ no

Which ones? _____

Have you taken medications? _____

Previously? ___ yes ___ no (if yes, which ones, dosage, when, for how long?) _____

_____

Recently? ___ yes ___ no (if yes, which ones, dosage, when, for how long?) _____

_____

Please list the medications you are taking now (name and dosage): _____

_____

Please list the supplements you are taking now (dosage if possible): _____

_____

_____

Do you smoke? ___yes If yes, how many cigarettes a day? _____

Have you had problems with drugs or alcohol? _____

Important

1. Please attach a color picture of yourself.

2. Please take your basal temperature three mornings in a row and record the results below. Put the thermometer (preferably the old fashioned mercury type) under your armpit for 10 minutes in the morning before getting up with as little movement as possible. Do not drink any alcohol the evening before. If you are female and still having menstrual periods, check your temp on days 2, 3, and 4 of your period.

T°_____ T°_____ T°_____

3. Please include a photocopy of any recent blood work and/or laboratory tests.

Name: _____ Date: _____

Please answer by placing a check mark in one box per question.

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
	0	+/-	+	++	+++
1. Is your resistance to stress low?					
2. Are you more tired in stressful situations?					
3. Are you easily confused or drowsy, esp. in stress?					
4. Is your blood pressure low?					
5. Do you have the sensation of spinning around when you get up?					
6. Are you down, tired, around 11am or 4pm?					
7. Are you attracted to sugary foods?					
8. Are you attracted to salty or spicy foods?					
9. Do you suffer from digestive troubles (stomach or intestinal)?					
10. Do you have a poor appetite?					
11. Are you thin (underweight)?					
12. Do you suffer from arthritis?					
13. Are you allergic: skin allergy?					
nose/throat/ears?					
food allergies?					
14. Do you suffer from asthma?					
15. Do you tolerate medications badly?					
16. Does your skin show broad brown spots of excessive pigmentation and/or broad white spots of depigmentation (vitiligo)?					
17. Are you easily euphoric (too enthusiastic)?					
18. Do you suffer from excessive agitation?					
19. Are you tired in the upright position and better in the horizontal position?					
20. Do you often have to urinate when you are standing up?					
21. Is your sleep light, anxious, and agitated?					
22. Is it difficult for you to fall back asleep if you have woken during the night?					

Please answer by placing a check mark in one box per question.

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
	0	+/-	+	++	+++
1. Are you sensitive to cold (in general)?					
Do you suffer from the cold at night?					
Do you suffer from cold hands?					
Do you experience dead white (winter) fingers?					
Do you suffer from cold feet?					
Do you have poor blood circulation?					
2. Do you have a tendency to gain weight?					
3. Are you tired?					
Mostly tired at rest, when you stop moving?					
Do you feel tired when you wake in the morning?					
Do you have a feeling of reduced vitality?					
4. Are you drowsy, sleepy during the day?					
Easily absent-minded?					
5. Are you depressed?					
6. Do you suffer from headaches?					
If yes, are they localized around the eyes?					
on the side(s) of your head?					
on the back of the head?					
diffusely over the while skull?					
7. Has your memory (capacity to retain information) weakened?					
Has your concentration (capacity to remain attentive) decreased?					
8. Do you feel nervous (tense)?					
Do you feel irritable (aggressive)?					
9. Are you swollen – around the eyes?					
-on the whole face?					
-on hands and feet?					
10. Do you suffer from constipation?					
Do you have a poor appetite?					
or, on the contrary, an exaggerated one?					

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
	0	+/-	+	++	+++
10. (cont.) Do you have a slow/difficult digestion (heavy stomach)?					
Are you intolerant to fats in your food?					
or chocolate?					
11. As a child, were you a bedwetter?					
12. Does your nose bleed easily?					
13. Do you have slow heart palpitations?					
Are you short of breath?					
14. Do you have varicose veins?					
If yes, do you suffer from them? Yes____ or No ____					
15. Do you get muscle cramps at night?					
in your feet?					
in your calves?					
in your hands?					
16. Are your joints stiff when you get up in the morning?					
Are your joints painful? Where?					
Does cold or wet weather aggravate them?					
Do you experience low back pain?					
17. Do you have respiratory tract allergies?					
18. Do you catch cold easily?					
19. Do you have frequent sore throats?					
20. Is your voice hoarse in the morning?					
21. Do you have ringing in the ears?					
22. Deafness?					
23. Do you experience weakness/dizziness during the day?					
around 11am Yes_____ No_____					
around 4pm Yes_____ No_____					
24. Does this disappear if you eat something sweet? Yes_____ No_____					
25. Is your skin dry?					
on your face?					
on your elbows?					
on your legs?					

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
	0	+/-	+	++	+++
25. (cont.) Do you perspire very little?					
26. Do you have brittle fingernails?					
Do your nails grow slowly?					
27. Are you experiencing hair loss?					
Does your hair grow slowly?					
28. Is your urine output scanty?					
Do you drink very little?					
29. Do you sometimes experience dizziness?					
30. Do you have a permanent feeling of being too hot?					
31. Do you perspire over your whole body?					
32. Are you thirsty?					
33. Do you lose weight despite eating a great deal?					
34. Do you have a feeling of inner trembling?					
35. Do you have rapid heart palpitations?					
36. Do you feel abnormally nervous, overexcited?					
Any additional comments?					

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
1. Do you feel you are aging?					
2. Is your back (more) bent (than before)?					
3. Do you accumulate fat on your: -breast?					
-belly?					
-thighs?					
4. Do you suffer from cellulite on your thighs?					
5. Is your posture sagging, less body tone?					
6. Do you feel constant (background) tiredness?					
7. Is it more difficult to recover from physical exertion?					
8. Are you depressed?					
9. Are you less dynamic, more passive?					
10. Has your memory decreased?					
11. Are you sometimes confused?					
12. Are you nervous inside? Irritable?					

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
13. Are you hyperemotional?					
14. Are you rigid (difficulty adapting to change)?					
15. Is your hair thin(ner)?					
16. Are you having: -diffuse hair loss?					
-hair loss on the upper scalp?					
17. Do you hear less clearly?					
18. Has your sight diminished: -for reading?					
-for distance?					
19 Is your vision dim or foggy?					
20. Do your gums bleed too easily?					
21. Have you lost teeth? If so, how many? _____					
22. Do you complain of: -dry eyes?					
-dry mouth?					
23. For women: -dry vagina					
24. Is your skin pale?					
25. Does your skin burn too easily in the sun?					
26. Is your skin wrinkled: -on your forehead?					
-around your eyes?					
-around your mouth?					
-on the palms of your hands?					
27. Do your nails show longitudinal lines?					
28. Are you easily out of breath when physically active?					
29. Do you experience pain in your chest from stress or physical exertion?					
30. Do you have varicose veins?					
31. Do you get hemorrhoids?					
32. Do you bruise easily?					
33. Are your muscles flabby: -on the arms and legs?					
-on the belly?					
34. Do you have low or decreased muscular strength?					
35. Do you experience hot flashes?					
36. Do you experience intense swelling?					
37. Do you suffer from: -neck pain?					

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
37. (cont.) Do you suffer from: -low back pain?					
-joint pains in the arms?					
-where? _____					
-joint pains in the legs?					
-where? _____					
38. Is it difficult to urinate?					
39. Do you have to urinate frequently?					
-during the day?					
-at night?					
40. Do you experience a burning sensation when urinating?					
41. <u>For adults</u>: Has your libido decreased?					
Do you suffer from decreased sexual potency?					
42. <u>For men</u>: Is your beard growing?					
Do you have hair on your chest?					
43. <u>For women</u>: Do you have poor axillary or pubic hair?					
Do you have more body hair than desired?					
Are your breasts drooping?					
Before your periods, are your breasts swollen and painful?					
Are your periods constantly painful?					
Are they intermittently with violent cramps?					
Are your menstrual cycles irregular? __ No (27-31 d.) __ Too short (26 d. or less) __ Too long (32+d.)					

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
1. Do you have thin (or thinner hair)?					
2. Is your face deeply wrinkled?					
Do you have: -pouches under the eyes?					
-sagging cheeks?					
-thin(ner) lips?					
-retracting gums?					

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
2. (cont.) Do you have: -thinned jaw bone(s)?					
-loose skinfolds under the chin?					
3. Do you feel that your body silhouette sags down?					
Have you lost muscle tone?					
4. Are you obese?					
Are your shoulders poorly or less muscled?					
Is the triceps muscle (at the back of your arm) sagging?					
Do you have less muscular, wrinkled, frailer hands?					
Are your lips less (or poorly) muscled?					
Are the inner sides of your thighs drooping?					
Do you have a flabby, saggy belly?					
Are there fat cushions just above your knees?					
5. Are you hyperemotional?					
6. Do you find your quality of life is low or has decreased?					
Do you feel uncomfortable?					
Are you often sick?					
Do you have frequent infections?					
7. Has your appetite decreased?					
Do you have a poor appetite for meat?					
8. Do you have poor or decreased muscular force?					
Easily exhausted when you are physically active?					
9. Do you suffer from constant tiredness?					
Is it difficult for you to stay up late (after midnight)?					
Is it hard to recover after staying up late (after midnight)?					
Is your resistance to stress low?					
Is it hard to recover after a stressful situation?					
Do you sometimes feel powerless to cope with certain situations?					
Do you feel incompetent?					
Are you not aggressive or assertive enough?					
Do you lose your self-control?					
Do you suffer from mood swings?					
Do you have low self esteem?					

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
9. (cont.) Are you anxious?					
Are you depressed?					
10. Do you have poor resistance to cold?					
11. As a child, did you have thin muscles?					
As a child, did you have thin bones?					
12. Do you have a tendency to isolate yourself socially, to stay at home sheltered?					
13. Is your skin thin (or thinner than before)?					
14. Is your voice sometimes harsh, do you scream easily?					
15. Do you have a repertory of sharp verbal retorts?					
16. Are you easily out of breath?					

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
1. Is your skin peeling between your toes?					
2. Do you suffer from mood swings?					
3. Do you suffer from energy swings?					
4. Do you suffer from a constant pressure on your head?					
5. For women: Do you suffer from a white vaginal discharge?					
Do you suffer from PMS with breast tenderness?					
6. Do you have dandruff?					
7. Does your scalp itch?					
8. Is your tongue coated?					
9. Do you suffer from a bloated belly?					
10. Do you have a lot of intestinal gas?					
11. Do you suffer alternatively from constipation and diarrhea?					
12. Do you suffer from peeling and/or itching red or white spots on your body (eczema, etc.)?					
13. Is your skin reddish or itching in the armpits, tops of your thighs, between your buttocks?					

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
Do you eat:					
-milk products: -milk?					
-buttermilk?					
-yogurt?					
-cheese?					
-cottage cheese?					
-butter?					
-sugars: -white sugar?					
-cane sugar?					
-candies?					
-chocolate?					
-cakes?					
-cookies?					
-jam?					
-honey?					
-maple syrup					
-fruits: (1 piece a day = a few)					
-in general?					
-rich in fiber (orange, grapefruit, etc.)?					
Are they ripe when you eat them? _____ yes _____ no					
-vegetables: -in general?					
Do you eat them: -raw?					
-boiled or steamed?					
-cooked in oil or butter?					
-as canned vegetables?					
-cereals: -in general?					
-bread?					
-whole grain bread?					
-crackers and toast?					
-granola and muesli?					
-sprouted grains?					
-meats: -in general?					
-poultry?					

5 possible responses to the questions:	No Never	Few Sometimes	Moderately Regularly	Much Often	Enormously Always
-meats (cont.) -beef, pork, lamb?					
Do you eat them: -broiled or barbecued?					
-cooked in butter or oil?					
-roasted in the oven?					
-boiled or steamed?					
-raw?					
-cold cuts (salami, bologna, etc.)?					
-canned meat?					
-fish: -Do you eat it? -smoked?					
-cooked in oil or butter?					
-boiled or steamed?					
-raw?					
-seafood?					
-eggs: -scrambled or fried?					
-soft boiled or poached?					
-raw?					
-organic food?					
-beverages: -sweet drinks (lemonade, gingerale)?					
-caffeinated drinks?					
-real coffee?					
-cola?					
-real tea?					
-coffee substitutes?					
-cereal, fruit coffee?					
-decaffeinated coffee?					
-herbal teas?					
-alcoholic drinks?					
-beer?					
-wine?					
-water?					
-sparking					
-plain?					