

Midway Center for Integrative Medicine

May 14, 2009

NAME:

DATE:

Past Medical History Surgeries:

Hospitalizations:

Major illnesses:

Major injuries:

Medication: 1) 2) 3) 4) 5)

6) 7) 8) 9) 10) 11)

Supplements: 1) 2) 3) 4) 5)

6) 7) 8) 9) 10) 11)

12) 13) 14) 15) 16) 17)

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 the questionnaire

Review of Systems

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Forgetful | <input type="checkbox"/> Vision | <input type="checkbox"/> Dry eyes |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Taste | <input type="checkbox"/> Smell |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Anxious | <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"/> Weight gain | <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"/> Year of last colonoscopy | <input type="checkbox"/> Year of last bone density scan | |
| <input type="checkbox"/> Year of last cholesterol levels | <input type="checkbox"/> Year of last blood sugar check | |
| <input type="checkbox"/> Year of last complete physical exam | <input type="checkbox"/> Year of last eye exam | |

Women: menopausal? (date of last menstrual period) 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
 Last pap smear (month/year) Date of last mammogram (month/year)

Men:

- | | | |
|---|---|---|
| <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 |
| <input type="checkbox"/> Date of last prostate blood test (PSA) | <input type="checkbox"/> Date of last prostate exam | |

- Would you like to schedule a complete physical exam?
 Would you like to receive comprehensive blood work to assess health status?
 Would you like to schedule detailed discussion of optimal nutrition?
 Would you like an appointment to discuss optimizing quality of life & life expectancy?
 Would you like an appointment to learn of optimal anti-aging regimens?
 Would you like to explore how bioidentical hormones can improve the quality of your life?
 Would you like an appointment to discuss an optimal supplement regimen?
 Would you prefer to use natural approaches instead of prescription medicine whenever possible?
 Would you like to discuss alternatives to your current medicine?