Midway Center for Integrative Medicine

Sept. 9, 2015

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:
What is your life vision, your passions?
Marital status: Single__ Married__ Divorced__ Widow__ Children's ages_____
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: Y (Yes), N (No), U (Unsure)
____Have you had a near-death experience?
____Have you learned to do your best to make the world better and trust the outcome?
____Are you doing the work that you love and making the world better?
____Do you share your feelings?
____Can you find someone to call for a favor?
____Do you belong to a social group or are part of larger community? (i.e. sociable?)
____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?
____Have you connected with 'God'? – intuitions, premonitions, or other?
____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?
____Have you eliminated judgment and criticism from your words and your life?

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

Checkmark next to those that apply-

___Sensitivity to light ___Tingling/odd sensations ___Perfume/odor sensitive
___Brain fog (fuzzy headed)___Headaches ___Hearing loss
___Impaired concentration ___Dizziness ___Vertigo
___Forgetful ___Vision ___Dry eyes
___Anxious ___Taste disturbance ___Smell disturbance
___Sad ___Weight gain ___Irritable
___Panic attacks ___Heat intolerance ___Cold intolerance
___Obsessive thoughts ___Palpitations ___Chest pain
___Shortness of breath ___Wheezing ___Fatigue
___Weight loss ___Lethargy ___Sleep disturbance
___Persistent cough ___Bloating ___Sound sensitivity
___Bloody bowel movement ___Black tarry bowel movement ___Constipation
___Diarrhea ___Abdominal cramps ___Hemorrhoids
___Heartburn ___Abdominal pain ___Nausea
___Joint pain ___Back pain ___Swelling
___Frequent urination ___Nighttime urination ___Blood in urine
___Cold feet ___Calf pain w/ exercise ___Near cell tower
___Change in moles ___Skin problem ___Muscles aches
___Twitches ___Tremors ___High cholesterol/triglyc
___Tick bite ___High blood sugar ___Low hormones
___Nighttime leg cramps ___Restless legs in bed ___Bowel movement daily?
___Put cell phone to ear ___Daytime drowsiness ___Dream recall?
___Sleep near a wall or outlet___Cordless telephones ___Wireless internet
___Symptoms only at (or water damage at) home, work, or school ___Snore

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 complete physical exam _____Year of last eye exam

Women: ___menopausal? _____ last menstrual period(mo/yr) ___menstrual cramps
_____Last pap smear (mo/year) _____Last mammogram - thermogram (mo/year)
___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) ___PSA level
___low sexual interest ___ poor sex performance ___loss of drive
___nighttime anxiety ___night sweats ___loss of confidence
___loss of strength ___discharge from penis ___ curved penis

MainConcerns_____
_____
_____
_____