Functional Medicine Timeline V2

This is one of the essential tools in Functional Medicine to help us understand your health condition, explain why the condition occurs and to find the root cause of the disease. Kindly answer the following information as honest and as accurate as possible.

Note: Collecting personal information such as gender, religion, complete address, civil status, and other relevant demographics is crucial in the context of medical consultations and implementing holistic advice. Understanding these aspects allows healthcare providers to tailor their approach, ensuring that treatment plans are not only medically sound but also culturally sensitive and aligned with the personal values and beliefs of each patient. For example, gender and cultural background can influence health risks and preferences, while civil status might affect a patient's support system and emotional well-being. By gathering this information, we can create a more comprehensive picture of each patient's unique circumstances, enabling us to offer personalized holistic advice that addresses not only physical health but also mental, emotional, and social factors. Rest assured that all information shared will remain confidential and will be used solely to enhance the quality of care and support we provide. Your participation is vital in helping us deliver a more effective and compassionate healthcare experience.

1. Email *

2. Date

Example: January 7, 2019

General Information

3. Name

4. Age

5. Date of Birth

Example: January 7, 2019

6. Gender

Mark only one oval.

- Female
- Male
- Prefer not to say

7. Civil Status

Mark only one oval.

- Single
- Married
- Divorced/Separated
- Widowed

8. Email

9. Address

10. Contact Number

11. Genetic Background

Mark only one oval.

- African American
- Native American
- Hispanic
- Caucasian
- Mediterranean
- Northern European
- Asian
- Other

12. Faith, Spiritualty or Religion

13. Emergency Contact

14. Relationship

15. Emergency Contact Number

16. How did you hear about our practice?

Mark only one oval.

- Clinic website
- Social media
- IFM/FMU Website
- Referral from a doctor
- Referral from friend/family member
- Other

Health Goals

17. What do you hope to achieve in your visit with us?

18. When was the last time you felt well?

19. Did something trigger your change in health?

20. What makes you feel better

21. What makes you feel worse?

22. How does your condition affect you?

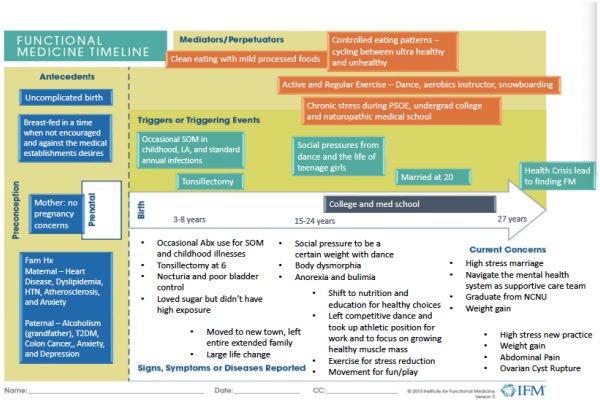
23. What do you think is happening and why?

24. What do you feel needs to happen for you to get better?If you have a magic wand what are the three things you would like to change or erase?

Creating Your Own Timeline (Prior to Birth up to the Present Time)

We believe in 4 C's in Functional medicine that what happened in the past does not mean irrelevant but instead they were **Contributory, Correlated, Causative, & Confirmatory** which connects to the present problem. Kindly refer to the image below to illustrate the Functional medicine timeline.

Sample Timeline. Take a moment to study the details.



Before Birth and at Birth

25. **Preconception** is the time before conception (the beginning of pregnancy). Parents may consider preconception care to help ensure a healthy pregnancy and delivery.

    Are both your parents ready and healthy?
    Are they taking already prenatal vitamins?
    Any unplanned pregnancy?

26. **Prenatal period** is the health care your mother get while she was pregnant.

    Provide information about doctor's visit, prenatal vitamins, illnesses, medication, hospitalization, ultrasound findings, stress, vices, and diet & lifestyle if known.

27. **Your Birth History**. Provide the following: home/hospital, vaginal birth/CS, reason for CS, term/pre-term, birth weight, duration of labor, birth complications, any resuscitation, etc. if known.

Infancy Period (0 to 1 yo) to Toddler period (1-5yo)

28. Breastfeeding history (from what age to what age). Any problem with lactation.

29. Formula milk feeding (from what age to what age). Any problem with formula?

30. Solid feeding (what age it was introduced and what type of food). Any feeding problem/reactions?

31. Vitamins/Supplements Given

32. Immunization History **(0-1yo)**. Were you able to receive all the vaccines on time? BCG (1 dose), Hep B (3 doses), DTAP (5 doses), Hib (4 doses), IPV (5 doses), Oral Polio (3 doses), Pneumonia (3 doses), Rotavirus (1), Flu (starts at 6 months then yearly)

33. Growth and Development **(0-1yo)**. Were you reaching your milestones as with normal infant? First raised head, and clasp hands at 3 months , rolled over, reach for objects, turn to voices, sat alone at 6 months, pulled up, walked with help at 7-12 months; language--cooing at 2 months, babbling at 6 months. Include weight and height (or physical growth) history if known

34. Growth and Development **(1-5yo)**. Were you reaching your milestones as with normal toddler? Walked alone at 1 yo to 15 months, scribbles fleetingly at 18 months/1 yr 6 months, run well and imitates line by 2 years, pedal a tricycle and jump around by 3 years, draws and copies circles by 4 years; Language-- talked 1 to 3 words by 1 year, 2-3 words by 2 years, converses well, asks "why" repeatedly, sing a song at 3 years, forms complex sentences at 4 years. Include weight and height (or physical growth) history if known

Present or Current Illness/Symptoms/Diagnosis

35. Describe your current problem/illness/symptoms here including start or date of onset, duration, interventions/medications/treatments, outcomes/result and diagnostics/lab test done.

Past Medical or Injury History

36. Enumerate the medical problem or injury (hospital or outpatient) you have experienced in the past in chronological order from infancy, toddler, grade school, high school, college and post college). Please indicate the year or age of the diagnosis or illness.

Past Surgical History

37. Enumerate the past surgeries you have had experienced in chronological order from infancy, toddler, grade school, high school, college and post graduate). Please indicate the year or age and the reason of the surgery.

Allergies

38. Name Medication/Supplement/Food and the reaction/effect. Also indicate the age or year of the allergy.

Medication or Supplement History

39. Have medications or supplements ever caused unusual side effects or problems? If yes, describe.

40. Have you used any of the these regularly or for a long time:

Check all that apply.

- [ ] NSAIDs (Advil, Alaxan, Arcoxia, Ponstan etc.)
- [ ] Tylenol (acetaminophen)
- [ ] Acid-blocking drugs (Zantac, Kremil-S, Pantoprazole (Nexium), Omeprazole, etc

41. How many times have you taken antibiotics?

Mark only one oval per row.

	<5	>5
Infancy/Childhood	◯	◯
Teen	◯	◯
Adulhood	◯	◯

42. Reason for use

43. Have you ever taken long term antibiotics? Yes or No (If yes, explain

44. How often have you taken oral steroids (e.g. cortisone, prednisone, etc.)?

Mark only one oval per row.

	<5	>5
Infancy/Childhood	◯	◯
Teen	◯	◯
Adulthood	◯	◯

45. Reason for use

Dental History

46. Check if you have any of the following, and provide number if applicable:

Check all that apply.

- [ ] Silver mercury fillings
- [ ] Gold fillings
- [ ] Root canals
- [ ] Implants
- [ ] Caps/Crowns
- [ ] Tooth pain
- [ ] Bleeding gums
- [ ] Gingivitis
- [ ] Problem with chewing
- [ ] Other dental concerns

47. If you checked any of the above, can you provide number or details as applicable. Indicate the year of the procedure or the year of the dental problem started in chronological order.

48. Have you had any mercury fillings removed?

Mark only one oval.

- Yes
- No

49. If yes, when was the mercury fillings removed?

50. How many fillings did you have as a kid?

51. Do you brush regularly?

Mark only one oval.

- Yes
- No

52. Do you floss regularly?

Mark only one oval.

- Yes
- No

Women's History

Skip this if you are a male

53. **Obstetric History**
Provide number and year if applicable:
-Pregnancy
-Miscarriages
-Abortions
-Living children
-Vaginal deliveries
-Cesarean
-Term births
-Premature birth

Provide reason for cesarean, miscarriages, abortions and premature birth if known

Birth weight of the largest baby and birth weight of the smallest baby

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? If yes, which one and please explain.

54. **Menstrual History:** Provide details as follows
-Age at first period
-Date of last menstrual period
-Length of cycle
-Time between cycles
-Cramping? (Yes or No)
-Pain? (Yes or No)
-Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? Yes or No (If yes, please describe
-Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? Yes or No (If yes, please describe
-Use of birth control pills, patch, Nuva ring or other (provide when and how long)
-Any problems with hormonal birth control? Yes or No (If yes, please describe
-Use of other contraception? Yes or no
-Which one? condoms, diaphragm, IUD, partner vasectomy
-Are you in menopause? Yes or no (If yes, age at last period)
-Was it surgical menopause Yes or no (If yes, explain surgery)
-Are you on hormone replacement therapy? Yes or No (If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?

55. **Gynecological Screening/Procedures:** Provide details and if applicable provide the date
-Last papsmear (normal/abnormal)
-Last mammogram (normal/abnormal)
-Last bone density (high/low or within normal range
-Other tests/procedures (list type and dates)

Men's History

Skip this if you are a female

56. Check box if applicable

Check all that apply.

- [ ] Testicular mass
- [ ] Testicular pain
- [ ] Prostate enlargement
- [ ] Prostate infection
- [ ] Change in sex drive
- [ ] Impotence
- [ ] Premature ejaculation
- [ ] Difficulty obtaining an erection
- [ ] Difficulty maintaining an erection
- [ ] Loss of control of urine
- [ ] Urinary urgency/hesitancy/change in stream
- [ ] Vasectomy
- [ ] Nocturia (urination at night)
- [ ] Sexually transmitted diseases

57. Provide details if applicable
-Nocturia - # of times per night
-Sexually transmitted diseases - describe

58. **Screening/Procedures**
-Last PSA test
-PSA level:
-Other tests/procedures (list type and dates)

Personal/Social History

This is a sensitive matter. All of the information you will provide will be kept confidential and shall not be disclosed without your consent.

59. Comment about the following and as much as possible provide a timeline in chronological order.
-Your parent's profession or background
-Living or financial status (past and current)
-Living arrangements and Social support
-How many are you in the family and what is your birth order
-Describe your relationship with your parents and how does it feel growing up as a kid
-Educational background
-Academic and extra curricular performance or activities
-Professional background
-Work experience
-Religious or spiritual belief
-Age of marriage (if applicable)
-Describe, past or current romantic relationship (if applicable)
-History of trauma or violence (either physical, mental, sexual, emotional, etc.)
-Stressors, mental, and emotional wellbeing
-Past diet and lifestyle habits prior to sickness
-Use of substances such as cigarette smoke, vape, alcohol, and illicit drugs
-Hobbies and interest
-Strengths and weaknesses
-Goals in life
-Advance directives
-Preventive practices or safety measures (e.g. vaccines, wearing seatbelts/helmets, sun block application, smoke detectors, home safety practices, regular doctor's visit)
-Sexual history (Sexual orientation, number of partners, or practices relevant to health risks)

Family History

60. List all the illnesses or diagnosis that are present in the family (i.e. mother, father, aunt, uncle, grandparents, cousins). Please specify the age of the diagnosis and age of death if relevant.

61. You have reached the end of the second part. After you click the submit button, please go back to this page and click the link to proceed to the next form. Thank you.

Lifestyle and Medical Symptom Assesment

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