SAGE CENTER FOR FUNCTIONAL HEALTH

Functional Medicine Adult Medical Questionnaire

Our ability to draw effective conclusions about your present state of health and how to improve it depends a great deal on your ability to respond thoughtfully and accurately to both these written questions and those from your FM provider during consultation. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Carefully answering the following question will make this visit efficient and effective. They will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

Your appointment is scheduled for Mon Tue Wed Thu at _____ am pm

Please be advised, failure to keep this appointment or cancel within a 24 hour period, will result in a $85 fee.

Name:		Email:	
Address:	City:	State:	ZIP:
Home:		Birth Date:	Age:
Work:		Place of Birth:	
Occupation:			
Referred by:		Ht: Wt:	Sex::
Today's Date:			

1. Please check appropriate box(es)

☐ African American	☐ Hipanic	☐ Mediterranean	☐ Asian
☐ Native American	☐ Caucasion	☐ Northern European	☐ Other

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible.

DESCRIBE PROBLEM	MILD/MODERATE/SEVERE	TREATMENT APPROACH	SUCCESS
a.			
b.			
c.			
d.			
e.			
f.			
g.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Wendy, age 7, sister.

_____

_____

_____

4. Do you have any pets or farm animals? Yes_____ No_____
If yes, where do they live? 1._____ indoors 2. _____ outdoors 3. _____ both indoors/outdoors

5. Have you lived or traveled outside of the United States? Yes_____ No_____
If so, when and where?

_____

_____

6. Have your or your family recently experienced any major life changes? Yes_____ No_____
If so, please comment:

_____

_____

7. Have you experienced any major losses in life? Yes_____ No_____
If so, please comment:

_____

_____

8. How important is religion (or spirituality) for you and your family's life?
a._____not at all important
b._____somewhat important
c._____extremely important

9. How much time have you lost from work or school in the past year?
a._____0-2 days
b._____3-14 days
c._____>15 days

10. Previous jobs:
_____

_____

11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse canals be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

a. Did you feel safe growing up?
   - ○ Yes
   - ○ No

b. Have you been involved in abusive relationships in your life?
   - ○ Yes
   - ○ No

c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
   - ○ Yes
   - ○ No

d. Do you currently feel safe in your home?
   - ○ Yes
   - ○ No

e. Do you feel safe, respected and valued in your current relationship?
   - ○ Yes
   - ○ No

f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
   - ○ Yes
   - ○ No

g. Would you feel safer discussing any of these issues privately?
   - ○ Yes
   - ○ No

12. Past Medical and Surgical History:

ILLNESS	WHEN	COMMENTS
Anema		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Crohn’s Disease of Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, convulsion, or seizures		
Gallstones		
Gout		
Heart attack/Angina		
Heart failure		
Hepatitis		

High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel		
Kidney stones		
Mononucleosis		
Pneumonia		
Rheumatic fever		
Sinusitis		
Sleep apnea		
Stroke		
Thyroid disease		
Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
Back injury		
Broken (describe)		
Head injury		
Neck injury		
Other (describe)		
DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
Barium Enema		
Bone Scan		
CAT Scan of Abdomen		
CAT Scan of Brain		
CAT Scan of Spine		
Chest X-ray		
Colonscopy		
EKG		
Liver scan		
Neck X-ray		
NMR/MRI		
Sigmoidoscopy		
Upper GI Series		
Other (describe)		

OPERATIONS	WHEN	COMMENTS
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Other (describe)		
Other (describe)		

13. Hospitalization:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON

14. How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

15. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc)?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

Medication Name	Date started	Dosage

Are you allergic to any medications? Yes_____ No_____

If yes, please list: _____

_____

17. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate) when possible.

Vitamins/Mineral/Supplement Name	Date started	Dosage

18. Childhood:

Questions	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

19. As a child, were there any foods that you had to avoid because they gave you symptoms?

Yes_____ No_____

If yes, please name the food and symptoms (Ex. milk—gas and diarrhea)_____

_____

_____

20. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page)

	Usual Breakfast	Ck		Usual Lunch	Ck		Usual Dinner	Ck
	None			None			None	
	Bacon/Sausage			Butter			Beans (legumes)	
	Bagel			Coffee			Brown rice	
	Butter			Eat in a cafeteria			Butter	
	Cereal			Eat in restaurant			Carrots	
	Coffee			Fish sandwich			Coffee	
	Donut			Juice			Fish	
	Eggs			Leftovers			Green vegetables	
	Fruit			Lettuce			Juice	
	Juice			Margarine			Margarine	
	Margarine			Mayo			Milk	
	Milk			Meat sandwich			Pasta	
	Oat bran			Milk			Potato	
	Sugar			Salad			Poultry	
	Sweet roll			Salad dressing			Red meat	
	Sweetner			Soda			Rice	
	Tea			Soup			Salad	
	Toast			Sugar			Salad dressing	
	Water			Sweetner			Soda	
	Wheat bran			Tea			Sugar	
	Yogurt			Tomato			Sweetner	
	Other: (List below)			Water			Tea	
				Yogurt			Water	
				Other: (List below)			Yellow vegetables	
							Other: (List below)	

21. How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea contain caffeine	
Diet sodas	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels)	
Sodas with caffeine	
Sodas without caffeine	

22. Are you on a special diet? Yes_____ No_____

_____ovo-lacto _____vegetarian _____other (describe)

_____diabetic _____vegan _____

_____dairy restricted _____blood type diet _____

23. Is there anything special about your diet that we should know? Yes_____ No_____

If yes, please explain:

_____

24. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc?

Yes_____ No_____

If yes, are these symptoms associated with any particular food or supplement(s)?

Yes_____ No_____

Please name the food or supplement and symptom(s). Ex. Milk — gas and diarrhea.

_____

_____

25. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc?

Yes_____ No_____

26. Do you feel much worse when you eat a lot of:

_____high fat foods _____refined sugar (junk food)

_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other_____

27. Do you feel much better when you eat a lot of:
_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other_____

28. Does skipping a meal greatly affect your symptoms? Yes_____ No_____

29. Have you ever had a food that you craved or really "binged" on over a period of time?
Food craving may be an indicator that you may be allergic to that food.
Yes_____ No_____
If yes, what food(s)_____
_____

30. Do you have an aversion to certain foods? Yes_____ No_____
If yes, what foods?_____

31. Please fill in the chart below with information about your bowel movements:

Frequency		Color		Consistency	
More than 3x/day		Medium brown consistently		Soft and well formed	
1-3x/day		Very dark or black		Often float	
4-6x/week		Greenish color		Difficult to pass	
2-3x/week		Blood is visible		Diarrhea	
1 or fewer x/week		Varies a lot		Thin, long or narrow	
		Dark brown consistenly		Small and hard	
		Yellow, light brown		Loose but not watery	
		Greasy, shiny appearance		Alternating between hard and loose/watery	

32. Intestinal gas: _____Daily _____Present with pain
_____Occasionally _____Foul smelling
_____Excessive _____Little odor

33. Have you ever used alcohol? Yes_____ No_____
If yes, how often do you now drink alcohol?
_____No longer drinking alcohol
_____Average 1-3 drinks per week
_____Average 4-6 drinks per week
_____Average 7-10 drinks per week

_____Average >10 drinks per week

Have you ever had a problem with alcohol? Yes_____ No_____
If yes, please indicate time period (month/year) From_____ To_____

34. Have you ever used recreational drugs? Yes_____ No_____

35. Have you ever used tobacco? Yes_____ No_____
If yes, number of years as a nicotine used_____, Amount per day_____, Year quit_____.
If yes, what type of nicotine have you used?
_____Cigarette _____Smokeless _____Cigar _____Pipe _____Patch/gum

36. Are you exposed to second hand smoke regularly? Yes_____ No_____

37. Do you have mercury amalgam fillings? Yes_____ No_____

38. Do you have any artificial going or implants? Yes_____ No_____

39. Do you feel worse at certain times of the year? Yes_____ No_____
If yes, when? _____spring _____summer
_____fall _____winter

40. Have you, to your knowledge, been exposed to toxic metals in your job or at home?
Yes_____ No_____
If yes, which one(s)? _____lead _____cadmium
_____arsenic _____mercury
_____aluminum

41. Do odors affect you? Yes_____ No_____

42. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not Apply
At school					
In you job					
In you social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

43. Have you ever had psychotherapy or counseling? Yes_____ No_____

Currently?_____ Previously?_____ If previously, from_____ to_____.

What kind?_____

Comments:_____

44. Are you currently, or have you ever been, married? Yes_____ No_____

If so, when were you married?_____ Spouse's occupation_____

Are you separated? Yes_____ No_____

Are you divorced? Yes_____ No_____

Are you remarried? Yes_____ No_____ Spouse's occupation_____

Comments:_____

45. Hobbies and leisure activities: _____

_____

46. Do you exercise regularly? Yes_____ No_____

If so, how many times a week?

_____1x

_____2x

_____3x

_____4x or more

When you exercise, how long is each session?

_____<15 min

_____16-30 min

_____31-45 min

_____>45 min

What type of exercise is it?

_____jogging/walking

_____basketball

_____home aerobics

_____tennis

_____water sports

_____other

48. Any other family history we should know about? Yes_____ No_____

If so, please comment:_____

47. Family History: For each member of your family, follow the grey or white line across the page and check the boxes for:
1. Their present state of health and
2. Any illnesses they have had

(Note: Except for spouse, Family refers to blood or natural relatives) PRINT NAMES BELOW	Good Health	Poor Health	Deceased	Write in age and cause of death. Include accidents and suicides.	Alcoholism	Allergies or Asthma	Alzheimers or Dementia	Anemia	Blood Clot Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Dis	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer
Father:																			
Mother:																			
Brothers/Sisters:																			
Spouse:																			
Child:																			
Child:																			
Child:																			
Child:																			
Paternal relatives (in ea box, write how many affected with condition)																			
Maternal relatives (in ea box, write how many affected with condition)																			