STARWEST MEDICAL GROUP
ADULT MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully to both these written questions and those posed by the clinician during your consultations. 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. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _____ Middle Name: _____ Last Name: _____

Birth Date: _____/_____/_____ Age: _____ Place of Birth: _____
City or town & country if not US

Occupation: _____ Work Phone: ( ) _____

Referred by: _____

Today's Date: _____ Email address: _____

Do you have an Advanced Directive, Living Will or Power of Attorney for health care (PDA) in the case that an injury or illness causes you to be unable to make healthcare decisions? Yes _____ No _____

1. 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
Example: Post Nasal Drip	**Moderate**	**Elimination Diet**	**Moderate**
a.			
b.			
c.			
d.			
e.			
f.			
g.			

2. Do you have any medicine/drug allergies? Yes _____ No _____
If yes, which drugs and what kind of reaction do you get?

_____

_____

3. Do you have any food allergies? Yes _____ No _____
If yes, please list with the reaction.

_____

_____

4. Do you have any environmental allergies? Yes _____ No _____

5. What medications are you taking now? Include non-prescription drugs.

MEDICATION NAME	DATE STARTED	DOSAGE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

6. Have you ever used tobacco? Yes _____ No _____
If yes, number of years as a nicotine user _____ Amount per day _____ Year quit _____
If yes, what type of nicotine have you used? _____ Cigarette _____ Smokeless _____ e-cig
_____ Cigar _____ Pipe _____ Patch/Gum

7. Are you exposed to second hand smoke regularly? Yes _____ No _____

8. Past Medical and Surgical History:

ILLNESS	WHEN	COMMENTS
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, convulsions, or seizures		
k. Gallstones		
l. Gout		
m. Heart attack/Angina		
n. Heart failure		
o. Hepatitis		
p. High blood fats (cholesterol, triglycerides)		
q. High blood pressure (hypertension)		
r. Irritable bowel		
s. Kidney stones		
t. Mononucleosis		
u. Pneumonia		
v. Rheumatic fever		

w. Sinusitis		
x. Sleep apnea		
y. Stroke		
z. Thyroid disease		
aa. Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
ab. Back injury		
ac. Broken (describe)		
ad. Head injury		
ae. Neck injury		
af. Other (describe)		
DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag. Barium Enema		
ah. Bone Scan		
ai. CAT Scan of Abdomen		
aj. CAT Scan of Brain		
ak. CAT Scan of Spine		
al. Chest X-ray		
am. Colonoscopy		
an. EKG		
ao. Liver Scan		
ap. Neck X-ray		
aq. NMR/MRI		
ar. Upper GI Series		
as. Other (describe)		
OPERATIONS	**WHEN**	**COMMENTS**
at. Appendectomy		
au. Dental Surgery		
av. Gall Bladder		
aw. Hernia		
ax. Hysterectomy		
ay. Tonsillectomy		
az. Other (describe)		
ba. Other (describe)		

9. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		

c.		
d.		
e.		

10. Other patient care team members:

Team Member Name	Specialty

11. Family History: Family refers to blood or natural relatives: Please list those who have had any of the following conditions:

Condition	Family Member & Age	Good Health	Poor Health	Deceased Cause of death
Alcoholism				
Allergies or Asthma				
Alzheimer's or Dementia				
Anemia				
Blood Clotting Problems				
Diabetes				
Cancer or Tumor / what kind				
Epilepsy				
Genetic Diseases / which ones				
Heart Trouble / what kind				
High Blood Pressure				
Kidney or Bladder Disease				
Nervous Breakdown				
Rheumatism or Arthritis				
Stomach or Duodenal Ulcer				

12. Any other family history we should know about? Yes _____ No _____
If yes, please comment:

_____

_____

13. 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.

VITAMIN/MINERAL/SUPPLEMENT NAME	DATE STARTED	DOSAGE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

14. Hobbies and leisure activities: _____

_____

15. Do you exercise regularly? Yes _____ No _____

If yes, how many times a week?

1. _____ 1x
2. _____ 2x
3. _____ 3x
4. _____ 4x or more

When you exercise, how long is each session?

1. _____ < 15 min.
2. _____ 16-30 min.
3. _____ 31-45 min.
4. _____ > 45 min.

What type of exercise is it?

_____ jogging/walking
_____ basketball
_____ home aerobics
_____ tennis
_____ water sports
_____ other _____

16. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes _____ No _____

If yes, which one(s)?

_____ lead
_____ arsenic
_____ aluminum
_____ cadmium
_____ mercury

17. Have you had any of the following immunizations?

Immunization	Yes	No	Date of last Immunization
Shingles			
Pneumonia (pneumococcal)			
Tetanus			
Influenza			

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

_____

_____

19. Do you have any pets?

If yes, where do they live? 1. _____ indoors 2. _____ outdoors 3. _____ both indoors & outdoors

20. How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important
b. _____ somewhat important
c. _____ Extremely important

21. Are you part of a religious/spiritual community? Yes _____ No _____

If yes, which one:

_____

22. Are there any specific practices/restrictions I should know about in providing your medical care? (e.g., dietary restrictions, use of blood products.) Yes _____ No _____

23. a. Have you ever used alcohol? Yes _____ No _____

b. 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

c. Have you ever had a problem with alcohol? Yes _____ No _____

d. If yes, please indicate time period (month/year): from _____ to _____

24. Have you ever used recreational drugs? Yes _____ No _____

If yes, which ones? _____

Are you currently using them? Yes _____ No _____

25. Have you lived or traveled outside of the United States? Yes _____ No _____

If so, when and where?

_____

26. Have you or your family recently experienced any major life changes? Yes _____ No _____

If yes, please comment:

_____

27. Previous Jobs:

_____

_____

28. 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 symptom (Example: milk – gas and diarrhea)

_____

_____

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

Cups of coffee containing caffeine	
Cups of tea containing caffeine	
Sodas with caffeine	

30. Are you on a special diet? Yes _____ No _____

_____ Vegetarian
_____ Vegan
_____ Blood type diet
_____ Diabetic
_____ Dairy restricted
_____ Other (describe):

_____

_____

31. 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 _____

32. Sexual Orientation:

_____ Straight or heterosexual _____ Lesbian, gay or homosexual _____ Bisexual

33. Gender Identity

_____ Male _____ Female

_____Transgender Male/Trans. Man/Female to Male

_____ Transgender Female/Trans. Woman/Male to Female

_____ Gender-queer, neither exclusively male nor female

34. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not Apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

35. Have you ever had psychotherapy or counseling? Yes _____ No _____
Currently? _____ Previously? _____ If previously, from _____ to _____.
What kind? _____
Comments: _____

_____

36. Are you currently, or have you ever been, married? Yes _____ No _____
If so, when were you married? _____ Spouse's occupation: _____
When were you separated? _____ Never _____
When were you divorced? _____ Never _____
When were you remarried? _____ Never _____ Spouse's occupation: _____
Comments: _____

37. Please check appropriate box(s):

African American ☐ Hispanic ☐ Mediterranean ☐ Asian ☐

Native American ☐ Caucasian ☐ Northern European ☐ Other ☐

FOR WOMEN ONLY (Questions 38-46):

38. Have you even been pregnant? (If no, skip to question 39) Yes _____ No _____
Number of miscarriages _____ Number of abortions _____ Number of preemies _____
Number of term births _____ Birth weight of larges baby _____ Smallest baby _____
Did you develop toxemia (high blood pressure)? Yes _____ No _____
Have you had other problems with pregnancy? Yes _____ No _____
If yes, please comment:

_____

_____

39. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram _____
Pap Smear: _____ Normal _____ Abnormal
Mammogram: _____ Normal _____ Abnormal

40. Have you even used birth control pills? Yes _____ No _____ If yes, when _____

41. Are you taking the pill now? Yes _____ No _____

42. Did taking the pill agree with you? Yes _____ No _____ Not applicable _____

43. Do you currently use contraception? Yes _____ No _____
if yes, what type of contraception do you use? _____

44. Are you in menopause? Yes _____ No _____ If yes, age at last period _____
If yes, do you take Hormone Replacement Therapy? Yes _____ No _____

45. How long have you been on hormone replacement therapy (if applicable)?

_____

46. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes _____ No _____ Not applicable _____

47. Please check if these symptoms occur presently or have occurred in the past 6 months:

General:	Mild	Moderate	Severe
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
Head, Eyes & Ears:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			
Musculoskeletal:			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches:			
Around eyes			
Arms or legs			
Muscle weakness			
Tendonitis			
Tension headache			
TMJ problems			
Mood/Nerves:			
Anxiety			
Auditory hallucinations			
Depression			

Mood/Nerves Continued:	Mild	Moderate	Severe
Difficulty:			
Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			
Numbness			
Phobias			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
Eating:			
Binge eating			
Bulimia			
Can't gain weight			
Carbohydrate craving			
Carb. intolerance			
Poor appetite			
Salt craving			
Digestion:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of:			
Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lip			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Gas			
Fissures			
Heartburn			
Hemorrhoids			
Intolerance to:			
Lactose			
All milk products			

Eating Cont.	Mild	Moderate	Severe
Intolerance to:			
Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
Skin Problems:			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			
Eczema			
Herpes – genital			
Hives			
Jock itch			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
Skin Itching:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			

Skin Itching Cont.	Mild	Moderate	Severs
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			
Skin Dryness of:			
Eyes			
Feet			
Any cracking?			
Any peeling			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
Lymph Nodes:			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
Nails:			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus – fingers			
Fungus – toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of:			
Finger nails			
Toenails			
White spots/lines			
Respiratory:			
Bad breath			
Bad odor in nose			
Cough – dry			
Cough – productive			
Hay fever:			
Spring			
Summer			
Fall			
Change of season			

Respiratory Cont.	Mild	Moderate	Severe
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
Cardiovascular:			
Angina/chest pain			
Breathlessness			
Heart murmur			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			
Urinary:			
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
Male Reproductive:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
Female Reproductive:			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			

Hoarseness			
Female Reproductive Cont.	**Mild**	**Moderate**	**Severe**
Premenstrual:			
Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Menstrual:			
Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			