**PEDIATRIC PARTNERS OF PONTE VEDRA 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 and accurately 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.

Name:       Email:

Address:       City, State, Zip:

Birth Date:      Home Phone (123-456-7890):       Work Phone:

Cell Phone:

Occupation:

Height:       ft       inches Weight:       lbs Gender (male or female):

Today’s Date:

Patient's Primary Care Physician:

Primary Care Physician's Address/Phone/Fax:

Preferred Local Pharmacy Name/Phone/Fax:

Do you have a preferred local compounding pharmacy? If so provide Name/Phone/Fax:

PRIVACY CONSTRAINTS *(Choose One)*:

No Constraints-OK to leave messages, send mail and e-mail

Restrictions-person to person communication with patient/guardian only

Other

Please check appropriate box(es):

African American  Hispanic  Mediterranean  Asian  Native American

Caucasian  Northern European  Other

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. |  |  |  |

1. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)

Example: Wendy, age 7, sister

1. Do you have any pets or farm animals? (Yes or no)

If yes, do they live indoors, outdoors, or both?

1. Have you lived or traveled outside of the United States? (Yes or no)

If so, when and where?

1. Have you or your family recently experienced any major life changes? (Yes or no)

If yes, please comment:

1. Have you experienced any major losses in life? (Yes or no)

If so, please comment:

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

a.  not at all important

b.  somewhat important

c.  extremely important

1. How much time have you lost from work or school in the past year?

a.  0-2 days

b.  3 –14 days

c.  15 or more days

1. Previous jobs:
2. 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 can also 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 yes or no to the following questions:

1. Did you feel safe growing up?
2. Have you been involved in abusive relationships in your life?
3. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
4. Do you currently feel safe in your home?
5. Do you feel safe, respected and valued in your current relationship?
6. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
7. Would you feel safer discussing any of these issues privately?
8. Past Medical and Surgical History:

|  |  |  |  |
| --- | --- | --- | --- |
|  | ILLNESSES | **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 |  |  |
|  | ILLNESSES | **WHEN** | **COMMENTS** |
| 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. | Sigmoidoscopy |  |  |
| as. | Upper GI Series |  |  |
| at. | Other (describe) |  |  |
|  | **OPERATIONS** | **WHEN** | **COMMENTS** |
| au. | Appendectomy |  |  |
| av. | Dental Surgery |  |  |
| aw. | Gall Bladder |  |  |
| ax. | Hernia |  |  |
| ay. | Hysterectomy |  |  |
| az. | Tonsillectomy |  |  |
| ba. | Other (describe) |  |  |
| bb. | Other (describe) |  |  |

1. Hospitalizations:

|  |  |  |
| --- | --- | --- |
| WHERE HOSPITALIZED | **WHEN** | **FOR WHAT REASON** |
| a. |  |  |
| b. |  |  |
| c. |  |  |
| d. |  |  |
| e. |  |  |

1. How often have you have taken antibiotics?

**< 5 times > 5 times**

|  |  |  |
| --- | --- | --- |
| Infancy/ Childhood |  |  |
| Teen |  |  |
| Adulthood |  |  |

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

**< 5 times > 5 times**

|  |  |  |
| --- | --- | --- |
| Infancy/ Childhood |  |  |
| Teen |  |  |
| Adulthood |  |  |

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

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Date started** | **Dosage** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |
| 8. |  |  |

1. Are you allergic to any medications? Yes or no       If yes, please list medication and reaction:
2. 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. |  |  |

1. Childhood:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Question** | **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? |  |  |  |  |

1. As a child, were there any foods that you had to avoid because they gave you symptoms? (Yes or no)

If yes, please: name the foods and symptoms (Example: milk – gas and diarrhea)

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Usual Breakfast | **√** |  | Usual Lunch | **√** |  | Usual Dinner | **√** |
| a. | None |  | a. | None |  | a. | None |  |
| b. | Bacon/Sausage |  | b. | Butter |  | b. | Beans (legumes) |  |
| c. | Bagel |  | c. | Coffee |  | c. | Brown rice |  |
| d. | Butter |  | d. | Eat in a cafeteria |  | d. | Butter |  |
| e. | Cereal |  | e. | Eat in restaurant |  | e. | Carrots |  |
| f. | Coffee |  | f. | Fish sandwich |  | f. | Coffee |  |
| g. | Donut |  | g. | Juice |  | g. | Fish |  |
| h. | Eggs |  | h. | Leftovers |  | h. | Green vegetables |  |
| i. | Fruit |  | i. | Lettuce |  | i. | Juice |  |
| j. | Juice |  | j. | Margarine |  | j. | Margarine |  |
| k. | Margarine |  | k. | Mayo |  | k. | Milk |  |
| l. | Milk |  | l. | Meat sandwich |  | l. | Pasta |  |
| m. | Oat bran |  | m. | Milk |  | m. | Potato |  |
| n. | Sugar |  | n. | Salad |  | n. | Poultry |  |
|  | Usual Breakfast | **√** |  | Usual Lunch | **√** |  | Usual Dinner | **√** |
| o. | Sweet roll |  | o. | Salad dressing |  | o. | Red meat |  |
| p. | Sweetener |  | p. | Soda |  | p. | Rice |  |
| q. | Tea |  | q. | Soup |  | q. | Salad |  |
| r. | Toast |  | r. | Sugar |  | r. | Salad dressing |  |
| s. | Water |  | s. | Sweetener |  | s. | Soda |  |
| t. | Wheat bran |  | t. | Tea |  | t. | Sugar |  |
| u. | Yogurt |  | u. | Tomato |  | u. | Sweetener |  |
| v. | Other: (List below) |  | v. | Water |  | v. | Tea |  |
|  |  |  | w. | Yogurt |  | w. | Water |  |
|  |  |  | x. | Other: (List below) |  | x. | Yellow vegetables |  |
|  |  |  |  |  |  | y. | Other: (List below) |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

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

|  |  |  |
| --- | --- | --- |
| a. | Candy |  |
| b. | Cheese |  |
| c. | Chocolate |  |
| d. | Cups of coffee containing caffeine |  |
| e. | Cups of decaffeinated coffee or tea |  |
| f. | Cups of hot chocolate |  |
| g. | Cups of tea containing caffeine |  |
| h. | Diet sodas |  |
| i. | Ice cream |  |
| j. | Salty foods |  |
| k. | Slices of white bread (rolls/bagels) |  |
| l. | Sodas with caffeine |  |
| m. | Sodas without caffeine |  |

1. Are you on a special diet? (Yes or no)

ovo-lacto  vegetarian  other (describe):

diabetic  vegan

dairy restricted  blood type diet

1. Is there anything special about your diet that we should know? (Yes or no)

If yes, please explain:

1. a. Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? (Yes or no)

b. If yes, are these symptoms associated with any particular food or supplement(s)? (yes or no)

c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

1. Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident

for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? (yes or no)

1. 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:

1. 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:

1. Does skipping a meal greatly affect your symptoms? (Yes or no)
2. Have you ever had a food that you craved or really "binged" on over a period of time? (Yes or no):

Food craving may be an indicator that you may be allergic to that food.

If yes, what food(s)?

1. Do you have an aversion to certain foods? (Yes or no)
2. If yes, what foods?
3. Please fill in the chart below with information about your bowel movements:

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

Intestinal gas:  Daily  Present with pain

Occasionally  Foul smelling

Excessive  Little odor

1. a. Have you ever used alcohol? (Yes or 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 or no):

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

1. Have you ever used recreational drugs? (Yes or no):
2. Have you ever used tobacco? (Yes or 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  Cigar  Pipe  Patch/Gum

1. Are you exposed to second hand smoke regularly? (Yes or no):
2. Do you have mercury amalgam fillings? (Yes or no):
3. Do you have any artificial joints or implants? (Yes or no):
4. Do you feel worse at certain times of the year? (Yes or no):

If yes, when?  spring  fall  summer  winter

1. Have you, to your knowledge, been exposed to toxic metals in your job or at home? (Yes or no):

If yes, which one(s)?  lead  cadmium  arsenic  mercury  aluminum

1. Do odors affect you? (Yes or no):
2. 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 |  |  |  |  |  |

1. Have you ever had psychotherapy or counseling? (Yes or no):

Currently?  Previously?  If previously, from       to

What kind?

Comments:

1. Are you currently married? (Yes or no):       If no, have you ever been, married? (Yes or no):

If so, when were you married?       Spouse's occupation (Yes or no):

When were you separated?       Never

When were you divorced?       Never

When were you remarried?       Never  Spouse’s occupation

Comments:

1. Hobbies and leisure activities:
2. Do you exercise regularly? (Yes or no):

If so, how many times a week?       When you exercise, how long is each session?

What type of exercise is it?

jogging/walking  tennis

basketball  water sports

home aerobics  other: