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Functional Medicine Health History Questionnaire

Please complete the following Functional Medicine Questionnaire to the best of your ability. You may need family members to help supply information. Your thoroughness and accuracy in answering all appropriate questions will help the doctor evaluate the root cause of your health concerns and determine an effective treatment program.

Note that we are interested in so-called minor symptoms as well as major problems. We know that in many doctor's offices there is some tendency not to mention too many symptoms for fear that the doctor will take you for a hypochondriac. The rules in our office are different. We are interested in **ANY** and all odd or unusual message you are getting from your body, even though it may be considered irrelevant to "making a diagnosis" or it may seem to you to be of no consequence to your health. Some such symptoms are useful clues in the kind of "medical detective work" we do. Please include as much information as you can on this form.

Please print or write legibly.

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem e.g. Headaches	**Onset** June 2007	**Frequency** 4 times per week	**Severity** Mild / moderate / severe
1.			
2.			
3.			
4.			
5.			
6.			
7.			

What diagnosis or explanation have been given to you?

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel **worse**?

What makes you feel **better**?

Please list all physicians you have seen for the above health conditions:

1.
2.
3.
4.
5.
6.

Please check all the Alternative Treatments you have tried for your condition(s)

None	Massage	Yoga	Environmental medicine
Chiropractic	Rolfing	Hypnosis	Nutritional Therapy
Acupuncture	Reiki	Ayurveda	Biological Dentistry
Iridology	Homeopathy	Light therapy	IV (chelation) therapy
Colonics	Biofeedback	Meditation	Naturopathic medicine

PAST MEDICAL & SURGICAL HISTORY

ILLNESSES	Date	Date	Date	Comments
Chicken Pox				
German Measles				
Measles				
Mononucleosis				
Mumps				
Whooping cough				
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue Syndrome				
Crohn’s Disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				
High blood pressure				
Irritable bowel				
Kidney stones				
Mononucleosis				
Pneumonia				
Rheumatic fever				
Sinusitis				

ILLNESSES	Date	Date	Date	Comments
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				
INJURIES	**Date**	**Date**	**Date**	**Comments**
Head Injury				
Neck Injury				
Back Injury				
Fracture				
Other (describe)				
DIAGNOSTIC STUDIES	**Date**	**Date**	**Date**	**Comments**
Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy				
Colonoscopy				
Upper GI Series				
Barium Enema				
CAT scan of Abdomen				
CAT scan of brain				
CAT scan of spine				
Liver scan				
Bone scan				
Neck X-rays				
Back X-rays				
MRI				
Bone Density Test				
Carotid Artery Ultrasound				
Blood Tests				
Other (describe)				
OPERATIONS	**Date**	**Date**	**Date**	**Comments**
Tonsillectomy				
Tubes in Ears				
Appendectomy				
Gall Bladder				
Hernia				
Hysterectomy				
Dental Surgery				
Other (describe)				
Other (describe)				

HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

PATIENT BIRTH HISTORY

Question	Yes	No	Don't Know	Comment
Were you a full term baby?				
A Preemie?				
Forcep delivery?				
Cesarean section?				
Epidural used?				
Breast fed?				
Bottle fed?				
When your mother was pregnant with you, did she:				
Smoke tobacco?				
Drink alcohol?				
Take estrogen?				

CHILDHOOD HEALTH HISTORY

Question	Yes	No	Don't Know	Comment
Did you live in an area with soft water?				
Hard water?				
As a child, did you consume a lot of the following:				
Sugar?				
Candy?				
Sweet foods?				
Soda?				
Diet soda?				
Question	**Yes**	**No**	**Don't Know**	**Comment**
White bread?				
Cookies?				

Ice Cream?				
Meat, vegetable & potato/rice/pasta diet?				
Vegetarian & grain based diet with little meat?				
Vegetarian diet with milk & eggs?				
Vegetarian diet without milk & eggs?				

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 e.g. wheat – gas and bloating

Food	Symptom	Other comments

AGE OF ONSET OF ILLNESSES

Please indicate which, if any, of the following problems/conditions developed when you were a child (ages birth to age12) by indicating the approximate age of onset.

_____ Frequent colds or flu
_____ Bronchitis
_____ Measles
_____ Chicken Pox
_____ Strep Infections
_____ Significant dental work
_____ ADD
_____ Difficulty learning:
_____ High # of absences from school
_____ Jaundice
_____ Ear infections
_____ Premature at birth
_____ Fever blisters
_____ Abusive or alcoholic parent (s)
_____Tonsillitis
_____ Ear Infections
_____ Mumps
_____ Whooping Cough
_____ Seasonal allergies
_____ Behavior problems
_____ Hyperactivity
_____ Frequent headaches
_____ Upset stomach, indigestion
_____ Colic
_____ Congenital abnormalities
_____ Pneumonia
_____ Parent (s) smoked
_____ Skin disorders (eczema)
_____ Major illness(s) that required hospitalization.

If yes, please explain your illness:

____
____
____
____
____
____
____

IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:

- ❑ Smallpox
- ❑ Tetanus
- ❑ Diphtheria
- ❑ Pertussis
- ❑ Polio (oral)
- ❑ Polio (Injection)
- ❑ Mumps
- ❑ Measles
- ❑ Rubella (German measles)
- ❑ Typhoid
- ❑ Cholera

FEMALE MEDICAL HISTORY (for women only)

OBSTETRICS HISTORY *Check box if yes and provide number of*

❑ Pregnancies ______________ ❑ Caesarean _______________ ❑ Vaginal deliveries _________

❑ Miscarriage ______________ ❑ Abortion _________________ ❑ Living Children ___________

❑ Post partum depression ❑ Toxemia ❑ Gestational diabetes

❑ Baby over 8 pounds ❑ Breast feeding For how long?_____________________________

GYNECOLOGICAL HISTORY

Age at 1st period:______ Menses Frequency: ______ Length: _________ Pain: Yes____ No ____

Clotting: Yes _____ No _____ Has your period skipped? _______ For how long? _______________

Last Menstrual Period: ________

Do you currently use contraception? Yes _____ No _____ If yes, what type do you use?

❑ Condom ❑ Diaphragm ❑ IUD ❑ Partner vasectomy

Have you ever used hormonal contraception? Yes ____ No _____ If yes, when __________________________

Use of hormonal contraception: ❑ Birth control pills ❑ Patch ❑ Nuva Ring How long?_______

Are you using the pill now? Yes ____ No _____ Did taking the pill agree with you? Yes _____ No _____

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? ❑ Yes ❑ No

Last Mammogram ___________________________ Breast Biopsy/Date ___________________________

Last PAP Test: ____________________________ Normal ______________ Abnormal ______________

Date of last Bone Density: ______________ Results: ❑ High ❑ Low ❑ Within normal range

Are you in menopause? Yes _____ No _____ Age at Menopause __________

Do you take: ❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin Other ____________

❑ Progesterone ❑ Provera Other ______________________________________

How long have you been on hormone replacement? ____

FAMILY HISTORY

(Place mark any health problem(s) your family has suffered with either now or in the past)

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Heart Attack												
Stroke												
Uterine Cancer												
Colon Cancer												
Breast Cancer												
Ovarian Cancer												
Prostate Cancer												
Skin Cancer												
ADD/ADHD												
ALS or other Motor Neuron Diseases												
Alzheimer's												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases (such as Lupus)												
Bipolar Disease												
Bladder disease												
Blood clotting problems												
Celiac disease												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental Sensitivities												
Epilepsy												
Flu												
Food Allergies, Sensitivities, Intolerances												
Genetic disorders												
Glaucoma												
Headache												
Heart Disease												
High Blood Pressure												
High Cholesterol												
Check Family Members that Apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**	**Aunts**	**Uncles**	**Other**

Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)												
Inflammatory Bowel Disease												
Insomnia												
Irritable Bowel Syndrome												
Kidney disease												
Multiple Sclerosis												
Nervous breakdown												
Obesity												
Osteoporosis												
Other												
Parkinson's												
Pneumonia/Bronchitis												
Psoriasis												
Psychiatric disorders												
Schizophrenia												
Sleep Apnea												
Smoking addiction												
Stroke												
Substance abuse (such as alcoholism)												
Ulcers												

Any other family history we should know about? Yes ______ No ______

If yes, please comment:

____

What is the attitude of those close to you about your illness? ❑ Supportive ❑ Non-supportive

Please indicate the occupation of your parents during your childhood:

____

____

REVIEW OF SYSTEMS

Check only those items with which you identify, ***past or present***. Ignore anything that does not apply to you.

GENERAL

- ❑ Fever
- ❑ Chills/Cold all over
- ❑ Aches/Pains
- ❑ General Weakness
- ❑ Difficulty sweating
- ❑ Excessive Sweating
- ❑ Swollen Glands
- ❑ Cold hands & Feet
- ❑ Fatigue
- ❑ Difficulty falling asleep
- ❑ Night Walker
- ❑ Nightmares
- ❑ No dream recall
- ❑ Early waking
- ❑ Daytime sleepiness
- ❑ Distorted Vision

SKIN:

- ❑ Cuts Heal slowly
- ❑ Bruise Easily
- ❑ Rash
- ❑ Pigmentation
- ❑ Changing Moles
- ❑ Calluses
- ❑ Eczema
- ❑ Psoriasis
- ❑ Dryness
- ❑ Oiliness
- ❑ Itching

- ❑ Acne
- ❑ Boils
- ❑ Hives
- ❑ Fungus on Nails
- ❑ Peeling Skin
- ❑ Cracking skin
- ❑ Shingles
- ❑ Nails Split
- ❑ White Spots/Lines on Nails
- ❑ Crawling Sensation
- ❑ Burning on Bottom of Feet
- ❑ Athletes Foot
- ❑ Cellulite
- ❑ Bugs love to bite you
- ❑ Have bumps on the back of arms and front of thighs
- ❑ Skin Cancer
- ❑ Strong body odor

Is you skin sensitive to the:

- ❑ Sun
- ❑ Fabrics ___________________
- ❑ Detergents______________

HEAD:

- ❑ Poor Concentration
- ❑ Confusion
- ❑ Headaches:
- ❑ After Meals
- ❑ Severe
- ❑ Migraine
- ❑ Frontal
- ❑ Afternoon
- ❑ Occipital
- ❑ Afternoon
- ❑ Daytime
- ❑ Relieved by:
- ❑ Eating Sweets
- ❑ Concussion/Whiplash
- ❑ Mental Sluggishness
- ❑ Forgetfulness
- ❑ Indecisive
- ❑ Face Twitch
- ❑ Poor Memory
- ❑ Hair Loss

EYES:

- ❑ Sand in Eyes
- ❑ Double Vision
- ❑ Blurred Vision
- ❑ Poor Night Vision
- ❑ Bright Flashes
- ❑ Halo around Lights
- ❑ Eye Pains
- ❑ Dark Circles under Eyes
- ❑ Strong Light Irritates
- ❑ Cataracts
- ❑ Floaters in Eyes
- ❑ Visual hallucinations

EARS:

- ❑ Aches
- ❑ Discharge/Conjunctivitis
- ❑ Pains
- ❑ Ringing
- ❑ Deafness/Hearing loss
- ❑ Itching
- ❑ Pressure
- ❑ Wear a hearing aid
- ❑ Frequent infections
- ❑ Tubes in ears
- ❑ Sensitive to loud noises
- ❑ Hearing Hallucinations

NOSE/SINUSES

- ❑ Stuffy
- ❑ Bleeding
- ❑ Running
- ❑ Discharge
- ❑ Watery Nose
- ❑ Congested
- ❑ Infection
- ❑ Polyps
- ❑ Acute smell
- ❑ Drainage
- ❑ Sneezing spells
- ❑ Post nasal drip
- ❑ No sense of smell
- ❑ Do the change of seasons tend to make your symptoms worse? Yes/No

If yes, is it worse in the:

- ❑ Spring
- ❑ Summer
- ❑ Fall
- ❑ Winter

MOUTH:

- ❑ Coated Tongue
- ❑ Sore Tongue
- ❑ Teeth Problems
- ❑ Bleeding Gums
- ❑ Canker Sores
- ❑ TMJ
- ❑ Cracked lips/ corners
- ❑ Chapped lips
- ❑ Fever blisters
- ❑ Wear dentures
- ❑ Grind teeth when sleeping
- ❑ Bad breath
- ❑ Dry mouth

THROAT:

- ❑ Mucus
- ❑ Difficulty Swallowing
- ❑ Frequent Hoarseness
- ❑ Tonsillitis
- ❑ Enlarged Glands
- ❑ Constant clearing of throat
- ❑ Throat closes up

NECK:

- ❑ Stiffness
- ❑ Swelling
- ❑ Lumps
- ❑ Neck glands swell

CIRCULATION/RESPIRATION:

- ❑ Swollen Ankles
- ❑ Sensitive to Hot
- ❑ Sensitive to Cold
- ❑ Extremities Cold or Clammy
- ❑ Hands/Feet go to sleep/numb
- ❑ High Blood Pressure
- ❑ Chest Pain
- ❑ Pain between shoulders
- ❑ Dizziness upon standing
- ❑ Fainting Spells
- ❑ High Cholesterol
- ❑ High Triglycerides
- ❑ Wheezing
- ❑ Irregular Heartbeat
- ❑ Palpitations
- ❑ Low exercise tolerance
- ❑ Frequent coughs
- ❑ Breathing heavily
- ❑ Frequently Sighing
- ❑ Shortness of breath
- ❑ Night Sweats
- ❑ Varicose Veins
- ❑ Mitral valve prolapse
- ❑ Murmurs
- ❑ Skipped heartbeat
- ❑ Heart enlargement
- ❑ Angina pain
- ❑ Bronchitis/Pneumonia
- ❑ Emphysema
- ❑ Croup
- ❑ Frequent colds
- ❑ Heavy/tight chest
- ❑ Past Heart Attack ?? When ________
- ❑ Phlebitis
- ❑ Spider Veins

GASTROINTESTINAL/DIGESTION

- ❑ Peptic/Duodenal Ulcer
- ❑ Poor Appetite
- ❑ Excessive Appetite
- ❑ Gallstones
- ❑ Gallbladder pain
- ❑ Nervous Stomach
- ❑ Full Feeling after meal
- ❑ Indigestion
- ❑ Heartburn
- ❑ Acid Reflux
- ❑ Hiatal Hernia
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Abdominal Pains/Cramps
- ❑ Gas
- ❑ Diarrhea
- ❑ Constipation
- ❑ Changes in Bowels
- ❑ Rectal Bleeding
- ❑ Tarry Stools
- ❑ Rectal Itching
- ❑ Use laxatives
- ❑ Bloating
- ❑ Belch frequently
- ❑ Anal itching
- ❑ Anal fissures
- ❑ Bloody stools
- ❑ Undigested food in stools

KIDNEY/URINARY TRACT:

- ❑ Burning
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Night time Urination
- ❑ Problem Passing Urine
- ❑ Kidney Pain
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Bladder infections
- ❑ Kidney infections
- ❑ Syphilis
- ❑ Bedwetting
- ❑ Have trichomonas

WOMEN'S HISTORY (for women only)

- ❑ Fibrocystic Breasts
- ❑ Fibroid Tumors/Breast
- ❑ Spotting
- ❑ Heavy Periods
- ❑ Fibroid Tumors/Uterus
- ❑ Painful periods
- ❑ Change in period
- ❑ Breast soreness before period
- ❑ Endometriosis
- ❑ Non-period bleeding
- ❑ Breast soreness during period
- ❑ Vaginal Dryness
- ❑ Vaginal discharge
- ❑ Had partial/total hysterectomy
- ❑ Hot Flashes
- ❑ Mood Swings
- ❑ Concentration/Memory Problems
- ❑ Breast cancer
- ❑ Ovarian cysts
- ❑ Pregnant
- ❑ Infertility
- ❑ Decreased Libido
- ❑ Heavy Bleeding
- ❑ Joint Pains
- ❑ Headaches
- ❑ Weight Gain
- ❑ Loss of Control of Urine
- ❑ Palpitations

MEN'S HISTORY (for men only)

Have you had a PSA done?
Yes ______ No ______
PSA Level:

- ❑ 0 – 2
- ❑ 2 – 4
- ❑ 4 – 10
- ❑ >10
- ❑ Prostate enlargement
- ❑ Prostate infection
- ❑ Change in libido
- ❑ Impotence
- ❑ Diminished libido
- ❑ Poor libido
- ❑ Infertility
- ❑ Lumps in testicles
- ❑ Sore on penis
- ❑ Genital pain
- ❑ Hernia
- ❑ Prostate cancer
- ❑ Low sperm count
- ❑ Difficulty Obtaining Erection
- ❑ Difficulty Maintaining an Erection
- ❑ Nocturia (urination at night)
- ❑ How many times at night? __________
- ❑ Urgency/Hesitancy/Change in Urinary Stream
- ❑ Loss of Control of Urine

JOINT/MUSCLES/TENDONS

- ❑ Pain wakes me up
- ❑ Weakness in Legs and arms
- ❑ Balance problems
- ❑ Muscle cramping
- ❑ Head injury
- ❑ Muscle Stiffness in Morning
- ❑ Damp weather bothers you

EMOTIONAL:

- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Blackouts
- ❑ Amnesia
- ❑ Had shock therapy
- ❑ Frequently keyed up and jittery
- ❑ Shaky
- ❑ Startled by sudden noises
- ❑ Often feel suddenly scared
- ❑ Go to pieces easily
- ❑ Forgetful
- ❑ Listless
- ❑ Withdrawn feeling
- ❑ Feel "lost" in time
- ❑ Had nervous breakdown
- ❑ Cry often
- ❑ Feel groggy
- ❑ Unable to concentrate
- ❑ Short attention span
- ❑ Vision changes
- ❑ Have overused drugs
- ❑ Considered a nervous person
- ❑ Worried over little things
- ❑ Anxiety
- ❑ Been addicted to drugs
- ❑ Frustration
- ❑ Numbness
- ❑ Often break out in cold sweats
- ❑ Profuse sweating
- ❑ Depressed
- ❑ Been admitted for psychiatric care
- ❑ Often awakened by frightening dreams
- ❑ Family member had nervous breakdown
- ❑ Use tranquilizers
- ❑ Aggressive
- ❑ Misunderstood by others
- ❑ Irritable
- ❑ Easily flare in anger
- ❑ Feeling of hostility
- ❑ Fatigue
- ❑ Hyperactive
- ❑ Restless leg syndrome
- ❑ Considered clumsy
- ❑ Unable to coordinate muscles
- ❑ Have difficulty falling asleep
- ❑ Have difficulty staying asleep
- ❑ Daytime sleepiness
- ❑ Am a workaholic
- ❑ Have considered suicide

Physicians Notes:

DENTAL HISTORY

Have you had sore gums (gingivitis) often over the years? Yes ____ No _____

Has ringing in the ears (tinnitus) been present? Yes ____ No _____

Have TMJ (temporal mandibular joint) problems been a concern? Yes ____ No _____

Do you often have a 'metallic' taste in your mouth? Yes ____ No _____

Do you have a lot of bad breath (halitosis) or white tongue (thrush)? Yes ____ No _____

Have you worn or do you presently wear braces? Yes ____ No _____

Do you have problems chewing? Yes ____ No _____

Do you floss regularly? Yes _____ No _____

Did your mother have dental fillings prior to giving birth to you? Yes ____ No _____

Did you have fillings as a child? Yes ____ No _____

If yes, about how many fillings did you have up to 18 yrs? _______

Did you have dental fillings as an adult? Yes ____ No _____

If yes, about how many fillings did you have after to 18 yrs? _______

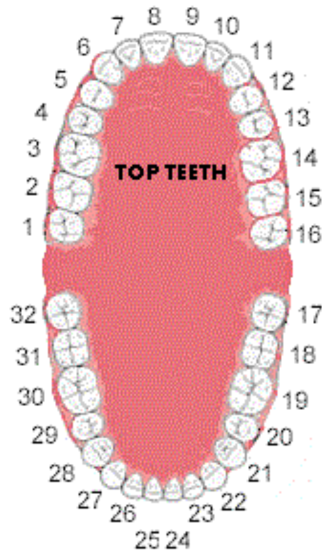
How many **metal amalgam** fillings do you have now? _______

Did you play with mercury as a child or adult? Yes ____ No _____

Have you eaten a lot of fish in your life? Yes ____ No _____

List the approximate age and the type of dental work done from childhood until present:

Please *circle the number* of the corresponding tooth or teeth you have had or still have problems with. Please state what type of problem you have had, for example: root canal, crown, abscessed tooth, partials, etc. and indicate which teeth have fillings.



RECORD ANSWERS:

MEDICATIONS & SUPPLEMENTS

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

	< 5 times	**> 5 times**
Infancy/Childhood		
Teen		
Adulthood		

STEROID USE

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

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

Indicate any medications you're currently taking or have taken in the last month:

- ❑ Acid Blocking Drugs
- ❑ Anti-anxiety medications
- ❑ Antibiotics
- ❑ Anticonvulsants
- ❑ Antidepressants
- ❑ Anti-fungals
- ❑ Aspirin/Ibuprofen
- ❑ Asthma inhalers
- ❑ Beta blockers
- ❑ Birth control pills/implant contraceptives
- ❑ Chemotherapy
- ❑ Cholesterol lowering medications
- ❑ Cortisone/steroids
- ❑ Diabetic medications/insulin
- ❑ Diuretics
- ❑ Estrogen or progesterone (pharmaceutical, prescription)
- ❑ Estrogen or progesterone (natural)
- ❑ Heart medications
- ❑ High blood pressure medications
- ❑ Laxatives
- ❑ Relaxants/Sleeping pills
- ❑ Testosterone (natural or prescription)
- ❑ Thyroid medication
- ❑ Acetaminophen (Tylenol)
- ❑ Ulcer medications
- ❑ Sildenafil citrate (Viagra or similar)

MEDICATION LOG

Please indicate the type of medications you are taking NOW or have RECENTLY. Include non-prescription drugs.

Medication Name	Date started	Dated Stopped	Dosage	# per day

SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name/Brand	Dose	Frequency	Dated Started	Reason for use

Have your medications or supplements ever caused you unusual side effects or problems?
Yes ____ No _____ If yes, please describe:

ALLERGIES

Medication/Supplement/Food	Reaction
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________