3/16/2022

NEW PATIENT HISTORY FORM

NAME: _____ AGE: ___ DATE: _____ TIME: _____ am/pm

A. MAJOR SYMPTOMS: Please note that this is a comprehensive history. Details are important in understanding your problems and their causes. The time you take to fill this out is time well spent!

1. Tell us what are your **major symptoms** or problems for which you have come to us today and their duration.

2. For **how long** have you been having each symptom that you have listed above? If you have not already answered it above, please do so now by specifying the duration next to each symptom.

B. TREATMENT RECEIVED

1. Number of physicians seen for the problems you have mentioned above, and their specialties or **attach a list:**

2. Tell us about the **treatment you have received** for the problems you have mentioned above, such as investigations, and the tests that you had (including x-rays, CT scans, blood tests), and medicines used – prescription or over-the-counter medicines, etc.

* 3. Tell us about the benefits of treatment received so far? Check one **(✓)** ( ) it helped ( ) did not help ( ) it hurt me or caused adverse effects. (You can check more than one option)

Explain:

C. EFFECT OF ILLNESS

1. How many days out of the month are your **good days**, i.e., when you feel perfectly fine and nothing seems to bother you: _____ days out of 30 days
2. How many days out of the month are your **bad days**, i.e., when your symptoms bother you: _____ days out of 30 days
3. List your **three** most bothersome symptoms here:

1. _____

2._____

3. _____

4. How are these symptoms bothersome for you, i.e. how are they interfering with your daily activities, family life or career? If you need more space, add additional page.

D. MEDICINES

1. List the medicines you are currently taking or **attach a list:**

2. Name of your Pharmacy: _____ Tel#: _____

3. Are you **allergic** to any medicines? *(Encircle your answer)* Yes No

Are you allergic to penicillin; sulfa ; other antibiotics; pain medicines; Anesthetics? *(encircle which applies to you).*

What other medicines are you allergic to?

E. SYMPTOMS

1. For women only:

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

0 = Never or almost never have the symptoms
1 = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

FEMALE REPRODUCTIVE SYSTEM

_____ Ever had vaginal yeast infection
Total number of yeast infections in your lifetime: _____
_____ Ever get any vaginal discharge at all
_____ Get premenstrual symptoms a few to several days before menses

What premenstrual symptoms do you have:

_____ premenstrual headaches
_____ premenstrual depression
_____ premenstrual irritability
_____ premenstrual anxiety
_____ premenstrual breast engorgement
_____ premenstrual breast pain & tenderness
_____premenstrual bloating
_____ premenstrual fluid retention
_____ premenstrual food cravings
_____ other premenstrual symptoms:
_____
_____ menstrual cramping
_____ pelvic pain
_____ vaginal pain
_____ breast pain *

Heavy menstrual bleeding Y N
Periods are irregular Y N
Miss periods/ infrequent periods Y N
Periods are heavy Y N
Periods are very light or spotting only Y N

Number of days you bleed _____ days
How long is your cycle? (28, 30 days, etc.) _____
Bleeding in-between menses* Y N
Headaches during menstruation Y N
Menopausal Y N
Hot flashes, Night sweats, Vaginal dryness, reduced or loss of libido (encircle)
Ever had miscarriage Y N # _____
_____ infertility
_____ rectal itch
Number of years you have taken **birth control pills**:

Age when birth control pills first started: _____
Are you currently on birth control pills: Yes No
Are you currently on female hormones: Yes No
Number of years you have taken female hormones: _____
Age when female hormones started: _____
Have You ever used IUD Yes No
Are you currently using IUD Yes No
Age when **menses** started: _____ (years)
When did you have last pap smear:_____
By Dr._____

When did you have last mammogram? _____

2. For Both Men and Women:
   (i)_____Have you ever taken **a lot of antibiotics** in your lifetime, including childhood: Yes No
   Please note: Taking a lot of antibiotics is defined as: if you have ever taken antibiotics more than 2-3 times in a given year, or taken them continuously for a month for any condition, such as acne, urinary tract infection, sinus or bronchial infection, etc.
   (ii)_____ Have you ever taken cortisone or cortisone-type medications such as prednisone in your lifetime, either as oral or by injection? Yes No
   Please give details:
   (iii)_____ Have you ever had rectal or jock itch?
   Number of times: _____
   (iv)_____ Have you ever had athlete's foot?
   Number of times: _____
3. For both men and women:

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

0 = Never or almost never have the symptoms
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DIGESTIVE TRACT

_____Ever get constipated *
How long ___ Years
_____Ever get diarrhea or loose stool *
_____Alternating between constipation and diarrhea
_____Gas
_____Belching
_____Bloating in abdominal area)
_____Ever get abdominal pain
_____Ever notice white, coated tongue
_____Heartburn
_____Nausea
_____ Vomiting
_____ Indigestion * - How long: _____ Years
_____Mucus in stool
_____ Foul smelling stool/gas
_____Bad Breath
_____Body Odor
_____Blood in stool
_____ Pass undigested food in stool/ or greasy stools
_____ Difficulty swallowing
_____ Poor appetite */ picky eater
_____Poor sense of taste; _____ Reduced or poor sense of smell
_____ Get hungry a lot
_____ Excessive Thirst
_____Dry mouth

HEAD, EMOTIONS, MIND AND NEUROLOGICAL

_____Headaches * How long:_____ Years
_____ Migraine headaches
Where does your head hurt: _____
Type of headache: throbbing – pressure, etc
What aggravates headaches: _____
_____Ever get depressed for no good reason
_____ Sadness
_____Anxiety* How long:_____ Years
_____Tense
_____Fear
_____Nervousness
_____Panic attacks
_____Become irritable or angry easily
_____Become aggressive easily
_____"Fly-off-the-handle"
_____Reduction in memory
_____Reduction in concentration / Easily distracted
_____Pressure in the head
_____Cannot think clearly/ ”cloudy” / ”foggy” / ”spacey” –
How long:___ Years
_____Difficulty finding words to express yourself
_____Difficulty remembering names, things, people
_____Loss of train of thought
_____Mood swings
_____ Poorly organized
_____ Mental fatigue
_____Difficulty in making decisions
_____Confusion
_____Poor comprehension
_____Learning difficulties or learning disabilities
_____Hyperactivity
_____Restlessness
_____Restless legs
_____Feels like “insides are racing”
_____Feel “sick all over”
_____Personality changes (especially observed by others)
_____Present performance inferior to prior performance in level of functioning. This is “not me”
_____Difficulty setting and reaching goals
_____Inability to cope well with daily and other stresses
_____Insomnia* (do not sleep well) How long: _____ Years
_____Difficulty remaining asleep #of hours you sleep___
_____ Drowsiness
_____Numbness/tingling – Where:
_____Decreased balance/unsteadiness
_____Decreased coordination
_____Tremors
_____Vertigo
_____Slurred speech

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

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ENERGY-ACTIVITY

_____Get tired easily/fatigue/low level of energy

How long:_____ Years
_____Get tired by the end of the day
_____Wake up tired/ hard time getting started in morning
_____Sleep excessively
_____Sleepiness during daytime
_____Feel excessively cold at temperatures other people are comfortable in

_____Hypoglycemic symptoms if skip or delay meals (e.g., weak, shaky, nervous, extremely uncomfortable) (*encircle which applies)*
_____ Weight Gain *
_____ Weight Loss *
_____ Underweight
_____ My weight is optimal i.e. I am satisfied with my weight
_____Muscular weakness or muscles tire easily

SKIN

_____Cold Hands
_____Cold Feet
_____Dry Skin
_____Facial puffiness in the morning
_____Genital itch
_____Genital rash
_____ Hives *
_____ Nails: brittle, white spots, thickened, discolored

_____Skin rashes/ Eczema
_____ Psoriasis *
_____Acne
_____Excessive/ unwanted hair on body or face (women)*
_____ Dandruff
_____Loss of scalp hair*
_____Describe your skin especially on face**: Loss of skin elasticity; Fine lines and wrinkles, deep wrinkles, Sagging skin; increase in pores size; age spots; skin getting thinner; changes in skin pigmentation; losing some youthful fullness of face; my skin is fine-don't see signs of aging (encircle)**

MUSCLES-JOINTS

_____Ever get muscle aches/muscle pains/muscle spasms* - How long:_____ Years
Where: arms; forearms, fingers; thighs; legs/feet ; chest wall; flank; neck; generalized pain abdominal wall muscles *(encircle that applies to you)*
_____Muscle cramps/Charley horses
Where: upper extremity; lower extremity; abdominal wall muscles; other _____
_____Leg cramping or leg pain on walking
_____Low back pain/spasm*
_____Pain or spasm/tightness, upper back
_____Temporo-mandibular (Jaw) pain
_____ Stiffness joints: which joints: shoulders: elbows wrists: hands; hips ; knees; ankle & foot: multiple joints

_____Pain or spasm, neck, shoulders, shoulder blades Specify the muscles that bother you:
_____ Tenseness/tightness neck, shoulder muscles
_____Muscle twitching Where:
_____Arthritis joint pain * - How long:_____ Years
Specify the joints that bother you: shoulders; elbows; wrists; hands); hips; knees; ankle & foot *; multiple joints; other joints:
_____
_____Carpal Tunnel Syndrome*
_____Prolapsed Disc – Neck, Back (encircle)
_____Any other painful condition: Explain

_____Ever had X-rays of Joints YES NO
Results:

CARDIOVASCULAR

_____High blood pressure *
How long:_____ Years
_____Rapid heartbeat
_____Irregular or skipped heartbeat
_____Palpitations
_____Angina or chest pain
_____Snoring, sleep apnea
_____Low blood pressure *
_____Hands & feet get cold, blue, painful, swollen on exposure to cold * *(encircle)*
_____Fluid Retention
_____Bruise easily

_____Faintness/dizziness *
_____ Lightheadedness
_____ Fainting spells
_____Postural dizziness, ie, getting dizzy on standing Abruptly*
_____Salt cravings
_____Swelling ankles, feet, or hands
_____Varicose veins
_____ Spider veins
_____High cholesterol/triglycerides *
_____Ever had echocardiogram, Stress test, EKG, Angiogram *(encircle)*
Results:

In this section, rate each of the following symptoms based upon your typical health profile.

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URINARY TRACT

_____Ever had bladder, kidney, or urinary tract infection
Number of times you had an infection: _____

_____Frequent urination

_____Burning on urination
_____Awaken at night to urinate
_____ Urinate a lot
_____ Blood in urine

NOSE

_____Stuffy nose :constant – daytime – nighttime – after meals – any time of year – blows nose constantly *(encircle what applies)*
_____Runny nose: with dust – with smoke – at meals or after meals – on arising – any time of year *(encircle what applies)*
_____Itching of nose
_____Sinus problem/sinus discomfort
How long:____Years
_____Hay fever
When do you have the symptoms: spring, early summer, late summer, fall, spring through fall *(encircle which applies)*

_____Use nasal sprays: Yes No
Name: _____
_____Odor of freshly cut grass bothers
_____ Nosebleeds
_____Sneezing
_____Post-nasal drip
_____Sinus pain
_____Sinus infections * No. of times/year _____
_____ Sores in the nose
_____ Ever had x-ray of sinuses YES NO
Results:

LUNGS

_____Wheezing – How long: _____ Years
_____Asthma* - How long:_____ Years
_____Bronchitis
_____Difficulty in breathing
_____Coughing up blood
_____ Cough up phlegm during meals or after meals

_____Tightness in chest
_____Chest congestion
_____Shortness of breath
_____Shortness of breath or wheezing on exertion
_____Chronic cough
_____Ever had chest x-ray YES NO Results:

MOUTH, THROAT, & EARS

_____Cold/flu-like symptoms
_____Sore throat
_____Hoarseness
_____Loss of voice
_____Canker sores
_____Swollen or discolored tongue, gums, lips
_____ Bad breath
_____Gums bleed on brushing or flossing
_____ Metallic taste, burning or tingling of tongue
_____ Excessive salivation
_____ Anything hurting in mouth? No Yes Where?

_____Feeling of fluid in ears
_____Itching of ears/moistness in ears
_____ear aches
_____Ear infection
_____Drainage from ears
_____Ringing in ears
_____Hearing loss
_____ Excessive wax in ears
_____Motion sickness

EYES

_____Watering/itching of eyes
_____Swollen, reddened, or sticky eyelids
_____Bags or dark circles under the eyes

_____Dry eyes
_____Blurred vision or tunnel vision (does not include near-sightedness or far-sightedness)
_____ Floaters in eyes

When did you have your last physical exam? _____ By Doctor: _____

Specialty: _____What was found and what was done?

When did you have last dental exam? _____What was found? _____

F. PAST SURGICAL HISTORY

1. **Did you ever have any surgery (encircle)** such as tonsillectomy, adenoidectomy, tubes in ears, sinus surgery, cholecystectomy (gallbladder removed), appendectomy, hysterectomy, ovaries removed, breast operations, hernia, splenectomy, knee surgery, breast implants, any other implants, Joint replacement: which joints?_____
2. Other surgery:_____

G. PAST MEDICAL HISTORY:

Have you ever been diagnosed with or had any of the following? Encircle what applies to you

1. Gastrointestinal tract: IBS (irritable bowel syndrome), peptic ulcer, acid reflux, GERD, rectal or colon polyps:; pancreatitis, blood in stool, diverticulitis, hemorrhoids, gall stone, gall bladder disease/gall bladder dysfunction, small intestinal bacterial overgrowth (SIBO), celiac disease NONE OF THESE
2. Psych/Neurological: Convulsive disorder/seizure disorder, Multiple Sclerosis, tics, Tourette's syndrome, Parkinson's disease, OCD (obsessive compulsive disorder), bipolar disorder, episodes of depression, post-traumatic stress disorder (PTSD) Head injury, _____ NONE OF THESE
3. Endocrine: Hypothyroidism, (low thyroid, goiter (enlarged thyroid), Grave's disease, received radioactive iodine for Grave's disease, chronic fatigue syndrome, high cholesterol, high triglycerides, diabetes, hypoglycemia, skin tags, potassium deficiency NONE OF THESE
4. Skin: Pimples, acne, acne rosacea, vitiligo (loss of skin pigmentation), warts, poison ivy/poison sumac rash, alopecia areata, basal cell carcinoma, melanoma, squamous cell carcinoma NONE OF THESE

5. Musculoskeletal: Arthritis, osteoarthritis, rheumatoid arthritis, bursitis, tendonitis: osteopenia(thinning of bone) osteoporosis (softening of bone), TMJ (clicking or popping of jaw), fibromyalgia, plantar fasciitis, NONE OF THESE

6. Cardiovascular: Sleep apnea, mitral valve prolapse, heart murmur, coronary artery disease, heart disease, heart attack: had stent put in, carotid artery blockage, stroke:, Raynaud's disease (hands and feet getting cold, blue and painful on exposure to cold); Postural Orthostatic Tachycardia Syndrome (POTS); NONE OF THESE

7. Urinary: Kidney or bladder stone: how many times? _____ passed them spontaneously, had lithotripsy done/surgically removed (encircle that applies) NONE OF THESE
8. Ear, Nose, Throat: Meniere's disease, hearing loss, fluid in ears, nasal polyps, fever blisters or cold sores NONE OF THESE
9. Pulmonary: Asthma, COPD (chronic obstructive pulmonary disease), RAD (reactive airway disease) NONE OF THESE
10. Eyes: Macular degeneration, dry eyes, cataract, glaucoma, night blindness, color-blindness NONE of THESE
11. Hematology: Anemia, hemochromatosis, vitamin B12 deficiency, pernicious anemia, iron deficiency, MTHFR Factor V Leiden disease, NONE OF THESE
12. Immune/Allergy: A. Lupus, Sjogren's syndrome, autoimmune disease, Low IgA; Low immunoglobulins; Low IgG subclasses; B. Severe or life-threatening reactions to any foods like peanuts, other nuts, fish, shellfish, any drug, latex or any other substance, allergy to stinging insects especially wasp, honey bee, hornet, yellow jacket, etc. (encircle) NONE OF THESE

    Please explain the reaction:
13. Women: Abnormal pap smear, uterine fibroids, genital warts, endometriosis, ovarian cyst, polycystic ovarian disease, fibrocystic breast, breast lump, breast tenderness, nipple discharge/blood, miscarriages, gestational diabetes (high blood sugar during pregnancy, any baby born over 9 lbs. NONE OF THE ABOVE
14. Men: Enlarged prostate, prostate cancer, prostatitis, vasectomy, erectile dysfunction, reduced libido, NONE OF THESE
15. Dental: Teeth grinding; gingivitis, periodontal disease, tooth decay, tooth erosion, tooth sensitivity, root canals-How many?_____ Number of teeth extracted _____
16. Toxic:, toxic metal overload like mercury, cadmium, lead, exposed to other chemicals including toxic chemicals, dust or fibers, metals, fumes, radiation, excessive humidity, mists, vapors, solvents, petroleum products, asbestos, gases, loud noise, vibration, extreme heat or cold, biological agents, ever lived or worked in a water damaged building? Did it have mold/mildew odor or visible mold? Did this building(s) have excessive moisture showing as moisture on surfaces like window pans? NONE OF THESE

H. INFECTIONS: Did you ever have any diseases such as infectious mono, hepatitis (Hepatitis A, Hepatitis B Hepatitis C), liver disease, bacterial infections like salmonella/shigella, parasitic diseases like giardia or any other parasitic infection, shingles, genital herpes, chlamydia, HPV (human papillomavirus), sexually transmitted disease, Lyme's disease, tick bite, HIV, risk factors for HIV, fungal infections of skin, toenails or fingernails, ringworm, pneumonia, tuberculosis (encircle that applies)? (encircle) Did you have COVID 19? No yes If yes, have you recovered completely? No Yes

Explain:

Did you get COVID 19 vaccine? No yes

I. SOCIAL AND ENVIRONMENTAL HISTORY

1	Do you **smoke or Vape?** How many years? ___	Y	N	11	What kind of **range (cook top)** do you have: gas electric		
	How many packs/day? ____			12	What kind of **dryer** do you have: gas electric		
	Years in college: _____ Degree: _____			13	What kind of **heat** do you have in the house: gas electric		
2	If so, do you have smoker's cough	Y	N		Encircle that applies: gas/wood fire place, use/do not use in winter		
3	Do you **Chew Tobacco?**	Y	N	14	What kind of **water heater** do you have: gas electric		
4	Tell us your habits regarding **drinking and drugs**.			15	Age of your residence: _____ years		
					House plants: How many? _____	Y	N
5	Does **anyone smoke or vape at home**?	Y	N	16	Type: house apartment town house trailer		
	Who does?			17	Do you have crawl space under the house	Y	N
6	Do you get exposed to **smoke at work**?	Y	N	18	Is there dampness/mustiness in basement?	Y	N
7	Tell us about your hobbies and recreations:			19	Humidifier: on furnace in bedroom	Y	N
				20	Ever had water leakage or damage in current house?	Y	N
8	Do you have **dog**? Indoor Outdoor (encircle)	Y	N	21	Exterminator Use in the house - # of times per year ___	Y	N
9	Do you have **cat**? Indoor Outdoor (encircle)	Y	N	22	Termite treatment of house?	Y	N
10	Any **other pets** including birds?	Y	N	23	Use of weed killers/bug sprays on lawn?	Y	N

24.Do any of the following smells bother you: Yes No
Tobacco smoke, exhaust fumes, bleaches, detergents, soaps,, ammonia, odor of new carpeting, asphalt, tar, pine odor, moth balls, insect sprays, pesticides, weed killers, fungicides, paints, varnishes, shellac, perfumes, hair sprays, cosmetics, air fresheners, gasoline products, natural gas, new cars, furniture polish, floor wax, candle odor, burning incense, rubbing alcohol, disinfectants, household cleaners, rubber, plastics, chlorinated water, newsprint, new fabric stores, spray cans, food odors, alcohol, formaldehyde, smoke from wood burning or fireplace, sulfur, latex, odors in salons and beauty parlors, potpourri, burning leaves, just about odors of any kind: *(encircle the odors that bother you)*

25. Do these chemicals bother you at low levels that do not bother other people? Yes No

26.How is your sense of smell: average above average (sharper) below average *(encircle one)*
How is your ability to detect leaking utility gas? above average; average below average *(encircle one)*

27. Does exposure to the following bother you: dust like visiting dusty building or while dusting or sweeping; mold/mildew odors, visiting damp/musty places; homes with dogs; homes with cats; *(encircle one)*

28.Have you ever lived or worked in a water damaged building or it had mold/mildew odor Yes No Explain:

29.Do foods bother you or disagree * with you, or you avoid, including alcohol and fatty foods ? Yes No

Explain:

30.Do you crave or over-consume sugar, bread, chocolate, ice cream, starchy foods, colas, caffeine, alcohol or have a sweet tooth? (*encircle what applies to you)* Yes No

31.If you skip caffeine, do you get caffeine withdrawal headaches? Yes No

32. Do you get sleepy, tired, feel cold or have chills, have runny nose, stuffy nose, phlegm, indigestion, Heartburn, diarrhea, loose stool, need to rush to bathroom, abdominal pain, stomach upset, headache, sweating or any other symptoms after meals or after certain foods? Yes No Explain:

33.Do you get alcohol hangovers? Yes No Even little booze bothers Explain:

34.Do you crave any other foods or certain foods make you feel better? Yes No Explain:

35. Are you vegetarian? Yes No
If yes, you should know that you are predisposed to deficiencies of zinc, iron, Vitamin B12, Vitamin D, carnitine, methionine and Co-enzyme Q10,

36. Do you use any artificial sweeteners like Equal, NutraSweet, Splenda, Sunnett Yes No (*encircle what applies to you)*

37. Do you have or had Alcohol dependency Yes No Explain:

38. Do you have or had Drug dependency Yes No Explain:

39. Do you eat organic foods or make active effort to eat organic foods Yes No

J. FAMILY AND SOCIAL HISTORY

1. Tell us about the health of your household (persons living at home besides the patient), i.e., are all of them in perfectly good health or have allergies or are prone to coughs, colds, bronchitis, wheezing, asthma, hay fever, ear infections, headaches, stomach aches, fatigue, or low level of energy, etc. Please provide the information below. Use additional page if needed.

PERSONS LIVING AT HOME BESIDES THE PATIENT

Name	Age	Relationship to the Patient	Any Health Problems? How bothersome are these problems on a scale of 0, 1, 2, 3, 4.
1.			
2.			
3.			
4.			
5.			
6.			

Are there any family members who have been treated, or are being treated at the Environmental Health Center? Yes No

If yes, who is being, or has been, treated here? _____

How did you find about us or who referred you to us: _____

Your occupation: _____No. of years at current job: _____

Spouse's (husband or wife) occupation: _____

In the case of a **child**:

Mother's occupation: _____

Father's occupation: _____

Parents' marital status: _____

Name of current school: _____

Tell us if anyone else in your **family (means blood relatives living at home or not)** has: allergies, sinus problems, asthma, COPD, hay fever, Meniere's disease, arthritis, rheumatoid arthritis, lupus, Mixed-connective tissue disease, Autoimmune hepatitis, fibromyalgia, chronic fatigue, colitis, irritable bowel, GERD, Gall Bladder Disease, Ulcerative colitis, Crohn's disease, Celiac disease, migraine headaches, **high blood pressure, heart disease (heart attack, coronary artery disease, congestive heart failure, stents, bypass surgery) stroke, high cholesterol , diabetes), obesity(i.e. people over 20 lbs above optimum weight), cerebral aneurysm (causing brain hemorrhage)** breast cancer, ovarian cancer, colon cancer, other cancer, Psoriasis, Eczema, polycystic ovarian disease (PCOD), Endometriosis, hypothyroid (low thyroid), Hashimoto's thyroiditis, Grave's disease or overactive thyroid), parkinsonism, MTHFR, depression, OCD, Tourette syndrome, Autism, mental illness, seizures, bipolar, manic-depression, Multiple sclerosis (MS), Alzheimer's, alcoholism, drug abuse, children with hyperactivity or learning problems, ADHD, ADD (encircle the problems that apply)

List any other significant illnesses in the family: _____

L. Thank You

We thank you for giving us the opportunity to help you.

Were you referred to us by one of our patients? YES NO

If yes, whom may we thank for your referral? _____

The first step towards your recovery is **foregoing the old model of treating symptoms with drugs and get hooked on new model of treating the cause.**

EDUCATION, NOT MEDICATION!

We emphasize education throughout our practice. Education means learning about the causes of illness and how they affect you and what to do about them.

Remember, you can never get rid of your symptoms or miseries until you treat the real causes of your illness. Nor you can cut down medical expenses until you are able to eliminate need for medicines. Probably you have already found it out if you have gone thru Merry Go 'Round of medicines and physicians. Are you ready to explore causes of your illness? Nothing will change, until you change-change your focus from treating symptoms to treating the cause!

K. PAST AND PRESENT CHRONOLOGICAL MEDICAL HISTORY

In this section, please give us a rundown of your health problems **from birth until your present age.** We will start your history from birth**(-not at your current age group)** and gradually progress to your current age. For earlier years, you may have to rely upon what your parents or relatives may have told you about your health.

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

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1 = Occasionally have it, effect is not severe
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Age 0 – 1

City & State born in:_____

_____ colicky
_____ feeding problems
_____ frequent coughs and colds
_____ ear infections
_____ asthma
_____ croup
_____ diaper rashes
_____ diarrhea
_____ constipation
_____ eczema/rashes
_____ overweight
_____ underweight
_____ adverse reactions to immunizations
_____ total # of antibiotic courses taken in 1st year_____
_____ do not know/I was told nothing
_____ Exposed to indoor tobacco smoke, dog, cat, gas cook top (encircle what applies)
_____ Lived in a water-damaged house or it had mold/mildew odor
_____ other significant problems & hospitalizations
Please give details:

Age 1-5 (preschool years)

_____ frequent coughs and colds
_____ sore throats
_____ strep throat
_____ tonsillitis
_____ ear infections
_____ bronchitis
_____ asthma/difficulty breathing (encircle)
_____ sinus problems/stuffy nose/runny nose (encircle)
_____ sinus infections
_____ adenoids
_____ diaper rashes
_____ diarrhea
_____ constipation
_____ stomachaches
_____ eczema/rashes
_____ overweight
_____ underweight
_____ hyperactivity/learning problems/ADHD
_____ behavioral/developmental/school problems
_____ adverse reactions to immunizations
_____ do not know/I was told nothing
_____ any surgery
_____ Exposed to indoor tobacco smoke, dog, cat, gas cook top (encircle what applies)
_____ Lived in a water-damaged house or it had mold/mildew odor
_____ other significant problems & hospitalizations
Please give details:

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

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Age 5-10 (early school years)

_____ frequent coughs and colds
_____ sore throats
_____ strep throat
_____ tonsillitis
_____ ear infections
_____ bronchitis
_____ asthma/difficulty breathing (encircle)
_____ sinus problems/stuffy nose/runny nose (encircle)
_____ sinus infections
_____ hay fever
_____ headaches
_____ pain: muscles/joints/back (encircle)
_____ fatigue
_____ overweight
_____ underweight
_____ adenoids
_____ bedwetting – till age: _____
_____ bladder/kidney infections
_____ diarrhea
_____ constipation
_____ stomachaches
_____ eczema/rashes
_____ hyperactivity/learning problems / behavioral problems/developmental problems / ADHD
_____ adverse reactions to immunizations
_____ chemical odors bothering
_____ do not know/I was told nothing
_____ Exposed to indoor tobacco smoke, dog, cat, gas cook top (encircle what applies)
_____ Lived in a water-damaged house or it had mold/mildew odor or a crawl space
_____ any surgery:
_____ other significant problems & hospitalizations
Please give details:

Age 10-20 (teen years)

_____ frequent coughs and colds
_____ sore throats
_____ strep throat
_____ tonsillitis
_____ bronchitis
_____ asthma/difficulty breathing (encircle)
_____ sinus problems/stuffy nose/runny nose (encircle)
_____ sinus infections
_____ hay fever
_____ headaches
_____ pain: muscles/joints/back (encircle)
_____ fatigue
_____ overweight/underweight (encircle)
_____ acne/ oily skin (encircle)
_____ menstrual cramping, heavy periods, irregular periods, missing periods, infrequent periods, light menstruation, spotting(encircle) (for women)
_____ menstrual problems (for women)
_____ infertility (for women)
_____ Excessive hair: chin, upper lip, face, breast area, back (encircle) (for women)
_____ vaginal infections (for women)
_____ bladder/kidney infections
_____ digestive problems
_____ any eating disorder; anorexia; bulimia
_____ hyperactivity/learning problems/trouble concentrating or remembering/ADHD (encircle)
_____ eczema/rashes
_____ depression/anxiety/insomnia (encircle)
_____ chemical odors bothering
_____ high blood pressure
_____ low blood pressure
_____ Exposed to indoor tobacco smoke, dog, cat, gas cook top(encircle)
_____ Lived in a water-damaged house or it had mold/mildew odor or a crawl space
_____ occupation if any:
_____ any surgery:
_____ marital status: No. of children:
_____ any significant emotional stress or abuse or trauma
_____ smoked during this time Age when started smoking: _____
_____ any drug abuse/illegal drugs/alcohol abuse (encircle)
_____ Domestic Abuse verbal or physical
_____ other significant problems & hospitalizations
Please give details:

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

0 = Never or almost never have the symptoms
1 = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

Age 20-30 (early adult years)

_____ frequent coughs and colds
_____ sore throats
_____ strep throat
_____ tonsillitis
_____ bronchitis
_____ asthma/difficulty breathing (encircle)
_____ sinus problems/stuffy nose/runny nose (encircle)
_____ sinus infections
_____ hay fever
_____ headaches
_____ pain: muscles/joints/back (encircle)
_____ fatigue
_____ overweight/underweight (encircle)
_____ acne/oily skin
_____ menstrual problems (for women)
_____ menstrual cramping, heavy periods, irregular periods (encircle) (for women)
_____ Excessive hair: chin, upper lip, face, breast area, back (encircle) (for women)
_____ vaginal infections (for women)
_____ bladder/kidney infections
_____ digestive problems
_____ any eating disorder
_____ depression/anxiety/insomnia (encircle)
_____ chemical odors bothering
_____ high blood pressure
_____ low blood pressure
_____ heart disease
_____reduced libido
_____ exposed to indoor tobacco smoke, dog, cat, gas cook top (encircle what applies)
_____ Lived/worked in a water-damaged house/building or it had mold/mildew odor or a crawl space
_____ occupation if any:
_____ any surgery:
_____ any significant emotional stress or abuse or trauma
_____ smoked during this time
_____ any drug abuse/illegal drugs/alcohol abuse(encircle)
_____ Domestic Abuse verbal or physical
_____ other significant problems & hospitalizations
Please give details:

Age 30-40

_____ frequent coughs and colds
_____ sore throats
_____ strep throat
_____ tonsillitis
_____ bronchitis
_____ asthma/difficulty breathing (encircle)
_____ sinus problems/stuffy nose/runny nose (encircle)
_____ sinus infections
_____ hay fever
_____ headaches
_____ pain: muscles/joints/back (encircle)
_____ fatigue
_____ overweight/underweight (encircle)
_____ acne/oily skin
_____ menstrual problems (for women)
_____menstrual cramping, heavy periods, irregular periods (encircle)
____ Infertility
____ Excessive hair: chin, upper lip, face, breast area, back (encircle) (for women)
_____ vaginal infections (for women)
_____ bladder/kidney infections
_____ digestive problems
_____ any eating disorder
_____ depression/anxiety/insomnia (encircle)
_____ chemical odors bothering
_____ high blood pressure
_____ low blood pressure
_____ heart disease
_____ reduced libido(for example, as compared to early 20s)
_____ exposed to indoor tobacco smoke, dog, cat, gas cook top (encircle what applies)
_____ Lived/worked in a water-damaged house/building or it had mold/mildew odor or a crawl space
_____ occupation if any:
_____ any surgery:
_____ any significant emotional stress or abuse or trauma
_____ smoked during this time
_____ any drug abuse/illegal drugs/alcohol abuse (encircle)
_____ Domestic Abuse verbal or physical
_____ other significant problems & hospitalizations
Please give details:

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

0 = Never or almost never have the symptoms
1 = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

Age 40-50

_____ frequent coughs and colds
_____ sore throats
_____ strep throat
_____ tonsillitis
_____ bronchitis
_____ asthma/difficulty breathing (encircle)
_____ sinus problems/stuffy nose/runny nose (encircle)
_____ sinus infections
_____ hay fever
_____ headaches
_____ pain: muscles/joints/back (encircle)
_____ fatigue
_____ overweight/underweight (encircle)
_____ bladder/kidney infections
_____ menstrual problems (for women)
_____ menstrual cramping, heavy periods, irregular periods (encircle) (for women)
_____ vaginal infections (for women)
_____ menopause (for women); age of onset _____
_____ digestive problems
_____ any eating disorder
_____ depression/anxiety/insomnia (encircle)
_____ chemical odors bothering
_____ high blood pressure
_____ low blood pressure
_____ heart disease
_____reduced libido(for example, as compared to early 20s)
_____ exposed to indoor tobacco smoke, dog, cat, gas cook top (encircle what applies)
_____ Lived/worked in a water-damaged house/building or it had mold/mildew odor or a crawl space
_____ occupation if any:
_____ any surgery:
_____ any significant emotional stress or abuse or trauma
_____ smoked during this time
_____ any drug abuse/illegal drugs/alcohol abuse (encircle)
_____ Domestic Abuse verbal or physical
_____ other significant problems & hospitalizations
Please give details:

Age 50-60+

_____ frequent coughs and colds
_____ sore throats
_____ strep throat
_____ tonsillitis
_____ bronchitis
_____ asthma/difficulty breathing (encircle)
_____ sinus problems/stuffy nose/runny nose (encircle)
_____ sinus infections
_____ hay fever
_____ headaches
_____ pain: muscles/joints/back (encircle)
_____ fatigue
_____ overweight/underweight (encircle)
_____ bladder/kidney infections
_____ menstrual problems (for women)
_____ vaginal infections (for women)
_____ menopause (for women); age of onset _____
_____ digestive problems
_____ any eating disorder
_____ depression/anxiety/insomnia (encircle)
_____ chemical odors bothering
_____ high blood pressure
_____ low blood pressure
_____ heart disease
_____ reduced libido(for example, as compared to early 20s)
_____ exposed to indoor tobacco smoke, dog, cat, gas cook top (encircle what applies)
_____ Lived/worked in a water-damaged house/building or it had mold/mildew odor or a crawl space
_____ occupation if any:
_____ any surgery:
_____ any significant emotional stress or abuse or trauma
_____ smoked during this time
_____ any drug abuse/illegal drugs/alcohol abuse (encircle)
_____ Domestic Abuse verbal or physical
_____ other significant problems & hospitalizations
Please give details: