

What Is Functional Medicine?

Functional medicine is an evolution in the practice of medicine that better addresses the healthcare needs of the 21st century. By shifting the traditional disease-centered focus of medical practice to a more patient-centered approach, functional medicine addresses the whole person, not just an isolated set of symptoms. Functional medicine practitioners spend time with their patients, listening to their histories and evaluating the interactions among genetic, environmental, and lifestyle factors that can influence long-term health and complex, chronic disease. In this way, functional medicine supports the unique expression of health and vitality for each individual.

Why Do We Need Functional Medicine?

- © **Our society is experiencing a sharp increase in the number of people who suffer from complex, chronic diseases**, such as diabetes, heart disease, cancer, mental illness, and autoimmune disorders like rheumatoid arthritis and fibromyalgia.
- © **The system of medicine practiced by most physicians is oriented toward acute care**, the diagnosis and treatment of trauma or illness that is of short duration and in need of urgent care, such as appendicitis or a broken leg. Physicians apply specific, prescribed treatments such as drugs or surgery that aim to treat the immediate problem or symptom.
- © **Unfortunately, the acute-care approach to medicine lacks the proper methodology and tools for preventing and treating complex, chronic disease.** In most cases it does not take into account the unique genetic makeup of each individual or factors such as environmental exposures to toxins and the aspects of today's lifestyle that have a direct influence on the rise in chronic disease in modern Western society.
- © **There's a huge gap between research and the way doctors practice.** The gap between emerging research in basic sciences and integration into medical practice is enormous—as long as 50 years—particularly in the area of complex, chronic illness. Functional medicine's aim is to evaluate, assess, and carefully enfold emerging research in a practical, efficient, and safe manner.
- © **Most physicians are not adequately trained to assess the underlying causes** of complex, chronic disease and to apply strategies such as nutrition, diet, and exercise to both treat and prevent these illnesses in their patients.

How Is Functional Medicine Different?

Functional medicine involves understanding the *origins, prevention, and treatment* of complex, chronic disease. Hallmarks of a functional medicine approach include:

- © **Patient-centered care.** The focus of functional medicine is on patient-centered care, promoting health as a positive vitality, beyond just the absence of disease. By listening to the patient and learning his or her story, the practitioner brings the patient into the discovery process and tailors treatments that address the individual's unique needs.
- © **An integrative, science-based healthcare approach.** Functional medicine practitioners look “upstream” to consider the complex web of interactions in the patient's history, physiology, and lifestyle that can lead to illness. The unique genetic makeup of each patient is considered, along with both internal (mind, body, and spirit) and external (physical and social environment) factors that affect total functioning.
- © **Integrating best medical practices.** Functional medicine integrates traditional Western medical practices with what are sometimes considered “alternative” or “integrative” medicine, creating a focus on prevention through nutrition, diet, and exercise; use of the latest laboratory testing and other diagnostic techniques; and prescribed combinations of drugs and/or botanical medicines, supplements, therapeutic diets, detoxification programs, or stress-management techniques.

Working with a Applied Kinesiologist / Functional Medicine Practitioner

Functional medicine practitioners promote wellness by focusing on the fundamental underlying factors that influence every patient's experience of health and disease.

The Functional Medicine Approach to Assessment

The Institute for Functional Medicine teaches practitioners how to assess the patient's fundamental clinical imbalances through careful history taking, physical examination, and laboratory testing. The functional medicine practitioner will consider multiple factors, including:

- © **Environmental inputs** – The air you breathe and the water you drink, the particular diet you eat, the quality of the food available to you, your level of physical exercise, and toxic exposures or traumas you have experienced all affect your health.
- © **Mind-body connections** – Psychological, spiritual, and social factors all can have a profound influence on your health. Considering these areas helps the functional medicine practitioner see your health in the context of you as a whole person, not just your physical symptoms.
- © **Genetic makeup** – Although individual genes may make you more susceptible to some diseases, your DNA is not an unchanging blueprint for your life. Emerging research shows that your genes may be influenced by everything in your environment, as well as your experiences, attitudes, and beliefs. That means it is possible to change the way genes are activated and expressed.

Through assessment of these underlying causes and triggers of dysfunction, the functional medicine practitioner is able to understand how key processes are affected. These are the body's processes that keep you alive. Some occur at the cellular level and involve how cells function, repair, and maintain themselves. These processes are related to larger functions, such as:

- how your body rids itself of toxins
- regulation of hormones and neurotransmitters
- immune system function
- inflammatory responses
- digestion and absorption of nutrients and the health of the digestive tract
- structural integrity
- psychological and spiritual equilibrium
- how you produce energy

All of these processes are influenced by both environmental factors and your genetic make-up; when they are disturbed or imbalanced, they lead to symptoms, which can lead to disease if effective interventions are not applied.

A Comprehensive Approach to Treatment

Most imbalances in functionality can be addressed; some can be completely restored to optimum function, and others can be substantially improved.

- © **Prevention is paramount.** Virtually every complex, chronic disease is preceded by long-term disturbances in functionality that can be identified and effectively managed.
- © **Changing how the systems function can have a major impact on the patient's health.** The functional medicine practitioner examines a wide array of available interventions and customizes a treatment plan including those with the most impact on underlying functionality.
- © **Functional medicine expands the clinician's tool kit.** Treatments may include combinations of drugs, botanical medicines, nutritional supplements, therapeutic diets, or detoxification programs. They may also include counseling on lifestyle, exercise, or stress-management techniques.
- © **The patient becomes a partner.** As a patient, you become an active partner with your functional medicine practitioner. This allows you to really be in charge of improving your own health and changing the outcome of disease.

The Highland Wellness Center

Visit us at www.truehealers.com or call us at 1-440-449-1866

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.

First Name: _____		Middle Name: _____		Last Name: _____	
Address: _____		City: _____		State: _____ ZIP: _____	
Home Phone: (_____) _____ - _____		Birth Date: ____/____/____		Age: _____	
		month day year			
Work Phone: (_____) _____ - _____		Place of Birth: _____			
Occupation: _____		City or town & country if not US			
Referred by: _____		Height: ____' ____"		Weight: _____ Sex: _____	
Today's Date _____					

1. Please check appropriate box(es):

- | | | | |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> 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
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
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 and outdoors

5. Have you lived or traveled outside of the United States? Yes___ No___
If so, when and where? _____

6. Have you or your family recently experienced any major life changes? Yes___ No___
If yes, 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 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 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

Adult Medical Questionnaire

- 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:

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)		

Adult Medical Questionnaire

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)		

13. Hospitalizations:

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

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		

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

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

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.

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

18. 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?				

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 symptom (Example: 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	√		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)	

21. 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	

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. a. Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.?
Yes___ No___
 b. If yes, are these symptoms associated with any particular food or supplement(s)?
Yes___ No___
 c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

25. 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___ 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:

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			

32. Intestinal gas: _____ Daily _____ Present with pain
 _____ Occasionally _____ Foul smelling
 _____ Excessive _____ Little odor

33. 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____
 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 user _____. 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 joints or implants? Yes____ No____

39. Do you feel worse at certain times of the year? Yes____ No____

If yes, when? _____spring _____fall
 _____summer _____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
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					

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 _____
 When were you separated? _____ Never _____
 When were you divorced? _____ Never _____
 When were you remarried? _____ Never _____ Spouse's occupation _____
 Comments: _____

45. Hobbies and leisure activities: _____

46. Do you exercise regularly? Yes____ No____
 If so, how many times a week? When you exercise, how long is each session?
 1. _____ 1x 1. _____ ≤15 min
 2. _____ 2x 2. _____ 16-30 min
 3. _____ 3x 3. _____ 31-45 min
 4. _____ 4x or more 4. _____ > 45 min

What type of exercise is it?
 _____ jogging/walking _____ tennis
 _____ basketball _____ water sports
 _____ home aerobics _____ other _____

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	Alzheimer's or Dementia	Anemia	Blood Clotting 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 each box, write in how many affected with condition):																				
Maternal relatives (in each box, write in how many affected with condition):																				

48. Any other family history we should know about? Yes___ No___

If so, please comment: _____

49. What is the attitude of those close to you about your illness?

_____ Supportive

_____ Non-supportive

FOR WOMEN ONLY (questions 50-58):

50. Have you ever been pregnant? (If no, skip to question 53.) Yes___ No___

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? Yes___ No___

Have you had other problems with pregnancy? Yes___ No___

If so, please comment: _____

51. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram _____

Pap Smear: ___ Normal ___ Abnormal

Mammogram: ___ Normal ___ Abnormal

52. Have you ever used birth control pills? Yes___ No___ If yes, when _____

53. Are you taking the pill now? Yes___ No___

54. Did taking the pill agree with you? Yes___ No___ Not applicable _____

55. Do you currently use contraception? Yes___ No___

If yes, what type of contraception do you use? _____

56. Are you in menopause? No ___ Yes ___ If yes, age at last period _____

Do you take: Estrogen?___ Ogen?___ Estrace?___ Premarin?___ Other (specify) _____

Progesterone?___ Provera? ___ Other (specify) _____

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

58. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes___ No___ Not applicable _____

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

GENERAL:	Mild	Mod- erate	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:	Mild	Mod- erate	Severe
Back muscle spasm			
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			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			

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MOOD/NERVES, Cont'd:	Mild	Mod- erate	Severe
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate 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 lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			

DIGESTION, Cont'd:	Mild	Mod- erate	Severe
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
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			

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SKIN PROBLEMS, Cont'd:	Mild	Mod- erate	Severe
Eczema			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
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			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

SKIN, DRYNESS OF:	Mild	Mod- erate	Severe
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			

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RESPIRATORY:	Mild	Mod- erate	Severe
Bad breath			
Bad odor in nose			
Cough - dry			
Cough - productive			
Hay fever : Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

URINARY:	Mild	Mod- erate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
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			

Adult Medical Questionnaire

FEMALE REPRODUCTIVE, Cont'd:	Mild	Mod- erate	Severe
<u>Premenstrual:</u>			
Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
<u>Menstrual:</u>			
Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Name _____ Date _____

Diet History

Approximately how many of the following foods do you consume **EACH WEEK**? When possible put Figures in blank spaces. If a food is eaten on only an occasion write **OCC** in the blank. If you do not consume a certain food write **NONE** in the blank. If a **YES** or **NO** answer is required, check the appropriate box.

Glasses of:

Whole milk _____
Skim milk _____
Buttermilk _____
Half & half _____
Servings of cheese _____
Kind of cheese? _____

Servings of:

Eggs _____
Beef _____
Pork _____
Bacon _____
Liver _____
Fowl _____
Fish _____
Lunch meat _____
Canned meat _____
Cereals _____
Pancakes _____
Waffles _____
Crackers _____
Rice _____
Macaroni _____
Spaghetti _____
Soup _____

Servings or portions of:

Pie/cake _____
Jell-O _____
Candy _____
Cookies _____
Doughnuts _____
Ice cream _____
Other desserts most commonly eaten: _____

Servings of Vegetables:

Potatoes: white, red or sweet _____
Carrots _____
Beans _____
Corn _____
Parsley _____
Squash _____
Spinach _____
Greens _____
Lettuce _____
Celery _____
Green Peas _____
Broccoli _____
Asparagus _____
Cole Slaw _____
Onions _____

Tomatoes _____
Green Peppers _____
Cabbage _____
Turnips _____
Others: _____

Servings of fruit:

Oranges _____
Grapefruit _____
Pineapple _____
Apples _____
Bananas _____
Prunes _____
Dates _____
Raisins _____
Figs _____
Grapes _____
Dried Apricots _____
Apple Sauce _____
Canned fruits _____
What dried or frozen fruits? _____
Other fruits? _____

Popcorn _____
Peanut butter _____
Nuts _____
Honey _____
Soda _____
Orange juice _____
Grapefruit juice _____
Tomato juice _____
Other juices? _____

What vegetable oils, fats or compounds do you use in cooking? _____

What vegetable oil do you use in salads? _____

What did you eat for breakfast yesterday? _____

What did you eat for lunch yesterday? _____

What did you have for supper yesterday? _____

What beverages did you have? _____

What did you have in between meals? _____

How many per day?

Pats of butter _____
Pats of margarine _____
White bread _____
Wheat bread _____
Rye bread _____
Corn bread _____
Other breads? _____
Sweet rolls _____

Glasses of water _____
Alcoholic beverages _____
Cups of coffee _____
Cups of Decaf _____
Cups of Tea _____

Cream in coffee, tea, etc. **Yes No**
How much sugar do you add to coffee or tea? _____

Do you use salt? _____
Sparingly _____
Freely _____
Moderately _____
Do you use vinegar? _____

Is this your average diet for the past three or four years? **Yes No**

What foods, if any, disagree with you? _____

Do you get indigestion? **Yes No**

Fond of fats? **Yes No**

Fond of sweets? **Yes No**

Fond of vegetables? **Yes No**

Fond of fruits? **Yes No**

Fond of bread? **Yes No**

Fond of butter? **Yes No**

Fond of cereal? **Yes No**

Signature