

DAVID LONDON MD

567 Vauxhall Street Extension, Suite 218, Waterford, CT 06385 phone: 860-443-5822 fax: 860-444-0581

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.			

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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?

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Yes No

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)		

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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		

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	

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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.	

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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. Any other family history we should know about? Yes ___ No ___

If so, please comment: _____

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

- ___ Supportive
 ___ Non-supportive

FOR WOMEN ONLY (questions 49-57):

49. 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: _____

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

Pap Smear: ___ Normal ___ Abnormal

Mammogram: ___ Normal ___ Abnormal

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

52. Are you taking the pill now? Yes___ No___

53. Did taking the pill agree with you? Yes___ No___ Not applicable ___

54. Do you currently use contraception? Yes___ No___

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

55. 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) _____

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

57. 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			

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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			