MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____

My ability to assess your present state of health and how to improve it depends on your ability to respond thoughtfully and accurately to both these written questions and my oral questions. Health is usually influenced by many factors, including lifestyle, potential toxic exposures, and genetics. Your careful consideration of each of the following questions will enhance our efficiency and make more effective use of your scheduled office visit time. ***(All information is kept strictly confidential.)*** **Please answer all questions frankly, to the best of your knowledge.**

1. What are your most important health concerns? *(in order of importance)*

(How long ago since you really felt well? _____)

	Year Started?	What else was happening in your life then?
(1)		
(2)		
(3)		
(4)		

2.

Other health problems:	Year started	Describe

3. What is your energy level now? ___Good ___Fair ___Poor ___Exhausted

4. Describe any digestive symptoms or problems: _____

_____

5. Sleep: Average #hours____ Difficulty going to sleep___ Difficulty staying asleep___

6. Chronic symptoms (note severity as "0, 1, 2, or 3"):

High stress now	Chronic stress
Get infections easily	Food sensitivities
Get digestive reactions easily	Chronic digestive problems
Autoimmune disease "flares" *(increases)*	Allergies, mucus, respiratory problems
Chronic inflammation*	Toxic chemical exposures

*(*Inflammation includes: pains, fatigue, digestive discomfort, mental fatigue, brain fog, etc)*

7. How often do you get a "flare" of inflammation or autoimmune symptoms?_____

8. Any known toxic exposure (heavy metals, toxic chemicals, toxic molds)**?** Yes___ No___

Describe: _____

Are you unusually sensitive to any chemicals or odors? Yes___ No___

Describe: _____

Dental amalgam fillings now? Yes___ No___ **Previously removed?** Yes___ No___

Dental root canals? Yes___ No___ **How many?** ___

9. Any **Chemical Injury warning symptoms**? When did they first start?_____
___Respiratory irritation/burning/congestion – sinus, nasal hoarseness and/or lower respiratory;
___GI, especially "acid-reflux-like", diarrhea, abdominal pain;
___Urinary urgency and/or frequency without infection;
___Migraines (not the same as neck-strain headaches);
___Skin – hives and other unexplained rashes;
___Aching and fatigue – these have external causes and internal biochemical changes.

***10.** For possible **Lyme Disease** exposure, and chronic symptoms that **come and go** and **migrate** around the body, see Lyme Questionnaire at http://www.dr-bradford.com/Online-Forms.html. (Some autoimmune diseases can be caused by Lyme.)*

11. Childhood:	**Yes**	**No**	**Don't Know**	**Comment**
Were you a full term baby?				
A preemie?				
Breast fed?				
Bottle fed?				
A lot of sugar/sweets in childhood?				

12. Are you allergic to any medications? Yes___ No___

List & describe reactions: _____

13. What drugs/medications are you taking now? (Include non-prescription & skin/eye.)

Medication Name	**Date started**	**Dosage & Comments**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

14. List all <u>vitamins, minerals, and other</u> nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible. *(Continue on extra page if needed.)*

Name of Supplement	**Date started**	**Dosage & Comments**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

15. Smoker? Never__ Past__ Present__ Amount_____

Alcohol? Never__ Past__ Present__ Amount_____

Other recreational drugs? Never__ Past__ Present__ Type/Amount_____

_____

16. *(Women)* OB/GYN:	**YEAR(S)**	**COMMENTS**
# of times Pregnant		
Last Menstrual Period		
GYN Problems (describe)		

17. Injuries:	**YEAR(S)**	**COMMENTS**
Head injury		
Back &/or Neck injury		
Fractures (describe)		
Others (describe)		

18. Surgeries:	**YEAR(S)**	**COMMENTS**
Gall Bladder removed		
Appendectomy		
Hysterectomy		
Dental Surgery		
Others (describe)		

19. Where Hospitalized:	YEAR(S)	COMMENTS

20. Have you lived or traveled outside of the United States? Yes__ No__

If so, when and where? _____

_____

_____

Any acute illnesses during these travels? _____

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

Example: Wendy, age 7, sister_____

_____

_____

22. Do you have any pets or farm animals? Yes__ No__

If yes, where do they live? __Indoors __Outdoors __Both indoors & outdoors

23. Have you or your family recently experienced any major life changes? Yes__ No__

If yes, please comment: _____

_____

24. Have you experienced any major losses in life? Yes___ No___

If so, please comment: _____

_____

_____

25. How important is religion or spirituality for you and your family's life?

___ Not important
___ Somewhat important
___ Very important

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

___ 0-2 days
___ 3 –14 days
___ >15 days

27. Current job: _____

Previous jobs: _____

_____