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.

Please answer all questions frankly, to the best of your knowledge.
(All information is kept strictly confidential.)

1. What are your most important health concerns?

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

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

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. **Stress level now:** Mild___ Moderate___ Severe___
   High stress level in past? Yes___ No___ Describe: _____

7. 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___
Dental amalgams previously removed? Yes___ No___
How many root canals have you had? ___

8. 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.

9. *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.)*

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

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

11. How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/ Childhood		
Teens		
Adulthood		

12. Are you allergic to any medications? Yes___ No___

List & describe reactions: _____

13. As a child, did you have to avoid any foods because they gave you symptoms?
Yes___ No___ Names & symptoms: _____

_____

14. Childhood:	**Yes**	**No**	**Don't Know**	**Comment**
Were you a full term baby?				
A preemie?				
Breast fed?				
Bottle fed?				
As a child did you eat a lot of sugar/sweets?				

15. 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. *(Continue on extra page if needed.)*

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

16. Smoker? Never__ Past__ Present__ Amount_____

Alcohol? Never__ Past__ Present__ Amount_____

Other recreational drugs? Never__ Past__ Present__ Type/Amount_____

_____

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

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

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

20. Where Hospitalized:	YEAR(S)	COMMENTS

21. Have you lived or traveled outside of the United States? Yes__ No__
If so, when and where? _____

_____

_____

Any acute illnesses during these travels? _____

22. With whom do you live? (Include children, parents, relatives, and/or friends; include ages.)
Example: Wendy, age 7, sister_____

_____

_____

23. Do you have any pets or farm animals? Yes__ No__
If yes, where do they live? __Indoors __Outdoors __Both indoors & outdoors

24. Have you or your family recently experienced any major life changes? Yes__ No__
If yes, please comment: _____

_____

25. Have you experienced any major losses in life? Yes___ No___
If so, please comment: _____

_____

_____

26. How important is religion or spirituality for you and your family's life?
___ Not important
___ Somewhat important
___ Very important

27. How much time have you lost from work or school in the past year?
___ 0-2 days
___ 3 –14 days
___ >15 days

28. Current job: _____

Previous jobs: _____

_____