ADULT MEDICAL QUESTIONNAIRE

Welcome to Santa Cruz Integrative Medicine! 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. Thank you for your help!

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____
month day year

Work Phone: (_____) _____-_____

Place of Birth:_____
City or town & country if not US

Occupation: _____

Referred by: _____ Height: ___′ ____″ Weight: _____ Sex: _____

Today's Date _____

1. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM/DATE OF ONSET	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			

2. Please check appropriate box(es):

☐ African American	☐ Hispanic	☐ Mediterranean	☐ Asian
☐ Native American	☐ Caucasian	☐ Northern European	☐ Other

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, what kind and 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

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)		
	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. Family History: Please check the box if any family members have suffered from any of the following, and write his/her relation on the line

- ☐ Alcoholism: _____
- ☐ Allergies/Asthma: _____
- ☐ Alzheimer's/Dementia: _____
- ☐ Anemia: _____
- ☐ Blood clotting issues: _____
- ☐ Diabetes: _____
- ☐ Cancer or Tumor: _____
- ☐ Epilepsy: _____
- ☐ Genetic Disease: _____
- ☐ Heart Trouble: _____
- ☐ High Blood Pressure: _____
- ☐ Kidney/Bladder Disease: _____
- ☐ Rheumatism/Arthritis: _____
- ☐ Stomach or Duodenal Ulcer: _____
- ☐ Other: _____

14. Hospitalizations:

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

15. How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

16. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

17. 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 medication and reaction:
_____
_____

18. 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.		
9.		
10.		

19. 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?				

20. 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)

21. Do you follow a special diet? Yes____ No____ If yes, please specify or check one of the following:
_____ lacto-ovo _____ vegetarian _____ other (describe):
_____ diabetic _____ vegan _____
_____ dairy restricted _____ blood type diet _____

22. 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	

23. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain:
_____

24. Do you feel you have <u>delayed</u> 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____

If yes, please explain: _____
_____

25. Do you feel much **worse** when you eat a lot of :

_____high fat foods
_____high protein foods
_____high carbohydrate foods (breads, pastas, potatoes)
_____refined sugar (junk food)
_____fried foods
_____1 or 2 alcoholic drinks
_____other _____

26. Do you feel much **better** when you eat a lot of :

_____high fat foods
_____high protein foods
_____high carbohydrate foods (breads, pastas, potatoes)
_____refined sugar (junk food)
_____fried foods
_____1 or 2 alcoholic drinks
_____other _____

27. Does skipping a meal greatly affect your symptoms? Yes____ No____

28. Have you ever had a food that you craved or really "binged" on over a period of time?
Yes____ No____
If yes, what food(s)? _____
_____

29. Do you have an aversion to certain foods? Yes____ No____
If yes, what foods? _____

30. Who does the cooking?_____

31. How is food prepared?_____

32. How often do you eat out and where?_____

_____

33. How many times a day do you eat? _____ What times do you eat during the day?_____

34. Have you lost or gained weight in the last year?_____Yes _____ No How Much_____

35. What do you feel triggered your initial weight gain/loss? (Circle One)
HEREDITY EATING HABITS STRESS HORMONES

BOREDOM SMOKING CESSATION OTHER _____

36. Was your weight gain/loss: (Circle One)

SUDDEN GRADUAL PROBLEM SINCE CHILDHOOD

37. Highest adult wt (year and wt)?_____
Lowest adult wt/when (year and wt)? _____

38. 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			

39. Intestinal gas:
_____Daily _____Present with pain
_____Occasionally _____Foul smelling
_____Excessive _____Little odor

40. a. Do you have a history of urine loss as a child ? Yes___ No ___
as an adolescent ? Yes___ No___
after childbirth ? Yes___ No___

b. Do you leak urine on the way to the bathroom? or when laughing?, coughing?, or exercising?
Yes___ No___

c. Have you had to restrict your activities due to incontinence or pain? Yes___ No___
d. Have you had changes in intimate relationships/sexual functioning due to incontinence or pain? Yes___No___

41. 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 _____.

42. Have you ever used recreational drugs? Yes____ No____

43. 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

44. Are you exposed to second hand smoke regularly? Yes____ No____

45. Do you have mercury amalgam fillings? Yes____ No____

46. Do you have any artificial joints or implants? Yes____ No____

47. 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

48. 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					

49. Have you ever had psychotherapy or counseling? Yes____ No____
Currently? _____ Previously? _____ If previously, from _____ to _____.
What kind? _____
Comments: _____

50. Are you sexually active? _____With men, women or both? _____Type of birth control? _____
Any questions/concerns about sexuality? _____

_____

Are you in a relationship? _____If yes, or how long with this partner? _____

If yes, any concerns about your relationship? _____

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: _____

51. Hobbies and leisure activities: _____
_____

52. Do you exercise regularly? Yes____ No____

If so, how many times a week?
1._____1x
2._____2x
3._____3x
4._____4x or more

When you exercise, how long is each session?
1._____ ≤15 min
2._____ 16-30 min
3._____ 31-45 min
4._____ > 45 min

What type of exercise is it?
_____jogging/walking
_____basketball
_____home aerobics
_____tennis
_____water sports
_____other _____

53. How would you rate your sleep? ____Good ____ Fair ____Poor
Do you fall asleep within 15 minutes? ____Y ____N
Do you awake in the middle of the night? ____Y ____N If so, how often and why?_____
What time do you typically go to bed _____ , and get up in the morning? _____
On average, how many hours of sleep do you get nightly? _____
Do you nap? ___Y ___N If so, how often and for how long? _____
Do you feel rested when you wake up in the morning? _____

For Women Only (answer only those that apply)**:**

I began menstruation at about age _____. If menstruating, the length of my cycle is approximately_____.

The length of bleeding is, on average _____. Are your menses very heavy or painful?_____

If heavy, how many pads or tampons do you use on the heaviest day?_____

Last menses was _____. Last pap smear _____. Last mammogram _____.

How many pregnancies have you had? _____ And how many children have you birthed? _____

Have you stopped menstruating? _____ If so when?_____ Do you have hot flashes or other menopausal symptoms, and if so, with what frequency?_____

_____

Have you ever been on hormone replacement therapy? If so, what kind and for how long? _____

_____

Have you had a bone density test? _____ Results and date? _____ Treatments? _____

Completed by_____ Date _____

Reviewed by Physician_____ Date _____

I understand that while seeing the providers at Santa Cruz Integrative Medicine, I also need a primary care physician for emergency care. My current primary care physician's name is

_____.

Name of clinic and address and phone if you know them

_____

_____

I am aware that I need a primary care physician for emergency care.

Signed _____ date_____

I became aware of Santa Cruz Integrative Medicine or Dr. Abrams or Dr.Shunney from or through

_____.