Elisa Song, MD | Donna Ruiz, MD | Suruchi Chandra, MD | Christina Peretz, MD | Kandice Stellmon, NC

Adult New Patient Health Questionnaire

Thank you for taking the time to fill out this new patient health questionnaire. This questionnaire is an important part of your initial consultation. Accurate completion of this form will ensure more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will assist your doctor in formulating the most appropriate treatment plan.

Personal Information
Patient's Name:__________________________________ Date of Birth:_______ Male Female
Requesting appointment with: ☐ **Dr. Christina Peretz** ☐ **Dr. Suruchi Chandra**
Form Completed by (include relation to patient):
Name/Address of Primary Care Physician:
Name/Address of Additional Therapists/Specialists Working With You (if any):
Name/Address of Additional Therapists/Specialists Working With You (if any):
Name/Address of Additional Therapists/Specialists Working With You (if any):

Please check appropriate box(es):

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

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Diagnosis

Please describe your main medical diagnoses or problem(s) that you would like addressed today:

Dates of diagnosis and diagnosing practitioner (please include address and telephone number):

What factors or events, if any, do you believe may have triggered your problem/illness?

What are your goals of treatment?

Please describe yourself, in as much detail as possible (personality, likes and dislikes, temperament, etc.). Tell me your story (you may use the additional sheet at the end of this document if necessary)…

Current Symptoms or Health Concerns

- ☐ Abdominal Pain
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune Problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Eczema
- ☐ Energy Problems
- ☐ Environmental Issues
- ☐ Frequent Infections
- ☐ Heart Disease
- ☐ Chronic Lyme or other Tick-Borne Illness
- ☐ Medications/Therapies
- ☐ Mental Health Issues
- ☐ Nutrition
- ☐ Seizures
- ☐ Sleep Issues
- ☐ Low libido/sex drive
- ☐ Reflux/heartburn
- ☐ Skin rashes
- ☐ Urinary problems
- ☐ Menstrual disorders/PMS
- ☐ Infertility
- ☐ Chronic pain
- ☐ Other Neurologic Issues (please describe):
- ☐ Other (please describe):

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Current Therapies

Please describe your current therapies:

- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Craniosacral
- ☐ Energy therapy
- ☐ Homeopathy
- ☐ Naturopathy
- ☐ Osteopathy
- ☐ Physical Therapy
- ☐ Other (please describe):

Please list all therapies tried and stopped (use additional sheet at the end of this document if necessary):

Therapy Tried	Reason Stopped

Past Medical History

Illnesses	When	Comments
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
Gout		
Heart attack/Angina		
Heart failure		
Hepatitis		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel		

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Past Medical History

Illnesses	When	Comments
Kidney stones		
Mononucleosis		
Pneumonia		
Rheumatic fever		
Sinusitis		
Sleep apnea		
Stroke		
Thyroid disease		
Other (describe)		
Injuries	**When**	**Comments**
Back injury		
Broken (describe)		
Head injury		
Neck injury		
Other (describe)		
Diagnostic Studies	**When**	**Comments**
Barium Enema		
Bone Scan		
CAT Scan of Abdomen		
CAT Scan of Brain		
CAT Scan of Spine		
Chest X-ray		
Colonoscopy		
EKG		
Liver scan		
Neck X-ray		
NMR/MRI		
Sigmoidoscopy		
Upper GI Series		
Other (describe)		

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Past Medical History

Operations	When	Comments
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Other (describe)		
Other (describe)		
Hospitalizations - Where	**When**	**For What Reason**

Childhood History

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. Was your development normal?				

Medication/Supplement History

Please list all current medications, vitamins, nutritional supplements, herbs, homeopathic remedies, etc. (use additional sheet at the end of this document if necessary):

Supplement/Medication	Dose	Frequency	Date Started

How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

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

	< 5 times	> 5 times
Infancy/ Childhood		
Teen		
Adulthood		

Allergies/Sensitivities

Please list any medications or supplements that you have had a reaction to. Describe the reaction:

Please list any other sensitivities that you have, or that you suspect you may have:

- ☐ Perfumes/cosmetics
- ☐ Cleaning products
- ☐ Soaps
- ☐ Detergents
- ☐ Dust
- ☐ Mold
- ☐ Pollens/Grasses
- ☐ Animals (dander)
- ☐ Gasoline
- ☐ Chemicals
- ☐ Other (please describe):
- ☐ Foods, which ones?

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Medication/Supplement History

Please list all medications/supplements stopped secondary to not working or negative response. If there was a negative response, please describe. (use additional sheet at the end of this document if necessary):

Supplement/Medication	Reason Stopped

Environmental History

Water: ☐ City ☐ Well **Purification system?** ☐ Yes ☐ No **If yes, please describe:**

Type of Heat: ☐ Electric ☐ Gas ☐ Oil ☐ Other **If other, please describe:**

Live near: ☐ Power lines ☐ Woods ☐ Industrial Areas ☐ Water (what kind?)

Bedding: ☐ Down ☐ Synthetic **Mattress/pillow cover?** ☐ Yes ☐ No

Flooring: ☐ Carpet ☐ Area rug ☐ Wood ☐ Other **If other, please describe:**

Does your home have a lot of: ☐ Dust ☐ Mold

Travel history:

Please list any other exposures you may have had in the past and present:

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Sleep History

Please describe the pattern and quality of your sleep? (i.e., do you sleep soundly, or toss and turn, have nightmares? Do you wake up refreshed?)

What time do you typically fall asleep at night?

What time do you typically wake up?

How many hours of sleep do you get every day?

Do you fall asleep easily? ☐ Yes ☐ No If no, please explain:

Do you stay asleep through the night? ☐ Yes ☐ No If no, please explain:

Exposure History

Have you ever used alcohol? ☐ Yes ☐ No

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

Have you ever had a problem with alcohol? ☐ Yes ☐ No

If yes, please indicate time period (month/year): from __________ to ____________

Have you ever used recreational drugs? ☐ Yes ☐ No

Have you ever used tobacco? ☐ Yes ☐ No

If yes, what type of nicotine have you used? ☐ Cigarette ☐ Smokeless ☐ Patch/Gum ☐ Cigar ☐ Pipe

If yes, number of years as a nicotine user: ______ Amount per day ______. Year quit ______.

Are you exposed to second hand smoke regularly? ☐ Yes ☐ No

Do you have mercury amalgam fillings? ☐ Yes ☐ No

Do you have any artificial joints or implants? ☐ Yes ☐ No

Do you feel worse at certain times of the year? ☐ Yes ☐ No

If yes, when? ☐ Spring ☐ Summer ☐ Fall ☐ Winter

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 ☐ Mercury ☐ Arsenic ☐ Aluminum ☐ Others: ________________________________

Do odors affect you? ☐ Yes ☐ No

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Digestive History

How often do you have a bowel movement?

What is your stool like (check all that apply)?

- ☐ Well-formed
- ☐ Mucousy
- ☐ Loose, falls apart
- ☐ Watery
- ☐ Small, hard pieces
- ☐ Greasy, floats
- ☐ Bloody
- ☐ Thin and long, ribbons
- ☐ Foul-smelling
- ☐ Painful
- ☐ Lots of undigested food particles
- ☐ Medium/dark brown
- ☐ Yellow/light brown
- ☐ Greenish
- ☐ Very dark or black
- ☐ Other (please describe):

Do you have heartburn or reflux? ☐ Yes ☐ No (If yes, please list any treatments):

Do you have frequent gas or belly bloating? ☐ Yes ☐ No (If yes, please describe):

Do you have any abdominal pain? ☐ Yes ☐ No (If yes, please describe how often and nature of pain):

Diet History

Please describe your current diet:

- ☐ No restrictions
- ☐ Gluten Free
- ☐ Casein Free
- ☐ Yeast Free
- ☐ Salicylate Free
- ☐ Low Phenolics
- ☐ Organic
- ☐ High Protein/Low Carb
- ☐ IgG Reactive Foods Avoidance
- ☐ Specific Carbohydrate Diet
- ☐ Diabetic Diet
- ☐ Vegetarian
- ☐ Vegan
- ☐ Bloodtype diet
- ☐ Ketogenic Diet
- ☐ Low Phenolics
- ☐ Organic
- ☐ High Protein/Low Carb
- ☐ Other (please describe):

Do you have any concerns about your current diet? ☐ Yes ☐ No
If yes, what concerns?

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Diet History
Please describe your typical breakfast:
Please describe your typical lunch:
Please describe your typical dinner:
Please describe your typical snacks:
What do you drink throughout the day?
Do you eat refined sugar? ☐ Yes ☐ No (If yes, what kind and how often):
Do you eat fast food? ☐ Yes ☐ No (If yes, what kind and how often):
Do you eat food with artificial colors/flavorings or preservations? ☐ Yes ☐ No (If yes, how often):
Do you eat artificial sweeteners? ☐ Yes ☐ No (If yes, what kind and how often):
Do you drink soda? ☐ Yes ☐ No (If yes, what kind and how often):
How many cups of caffeinated coffee or tea do you drink daily?
Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc? ☐ Yes ☐ No **If yes, are these symptoms associated with any particular food or supplement(s)? ☐ Yes ☐ No** **Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.**
Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or m **such as fatigue, muscle aches, sinus congestion, etc.? ☐ Yes ☐ No** **Please describe:**

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Diet History

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: ______________________________

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: ______________________________

Does skipping a meal greatly affect your symptoms? ☐ Yes ☐ No

Have you ever had a food that you craved or really "binged" on over a period of time? ☐ Yes ☐ No

Food craving may be an indicator that you may be allergic to that food.

If yes, what food(s)?

Do you have an aversion to certain foods? ☐ Yes ☐ No

If yes, what foods?

Please list all diets tried and stopped (use additional sheet at the end of this document if necessary):

Diet Tried	Reason Stopped

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Social History

How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Please list any pets in the house:

Please describe family relationships:

Please describe any recent stressful events (life changes, losses, births, deaths, divorce, remarriage, moves, illness, financial problems, arguments with family/friend, etc.):

Hobbies and leisure activities:

Do you exercise regularly? ☐ Yes ☐ No

If so, how many times a week?
- ☐ 1x
- ☐ 2x
- ☐ 3x
- ☐ 4x or more

When you exercise, how long is each session?
- ☐ ≤15 min
- ☐ 16-30 min
- ☐ 31-45 min
- ☐ > 45 min

What type of exercise is it?
- ☐ Jogging/walking
- ☐ Basketball
- ☐ Home aerobics
- ☐ Tennis
- ☐ Water sports
- ☐ Other: ______________________________

What is the attitude of those close to you about your health or illness?
- ☐ Supportive
- ☐ Non-supportive

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For Women Only

Have you ever been pregnant? ☐ 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 high blood pressure and/or pre-eclampsia? ☐ Yes ☐ No

Have you had other problems with pregnancy? ☐ Yes ☐ No

If so, please comment: ____

Age at first period: _____ Date of last Pap Smear: __________ Date of last Mammogram: __________

Pap Smear: ☐ Normal ☐ Abnormal

Mammogram: ☐ Normal ☐ Abnormal

Have you ever used birth control pills? ☐ Yes ☐ No If yes, when: _____________________

Are you taking the pill now? ☐ Yes ☐ No

Did taking the pill agree with you? ☐ Yes ☐ No ☐Not applicable

Do you currently use contraception? ☐ Yes ☐ No

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

Are you in menopause? ☐ Yes ☐ No If yes, age at last period: __________

Do you take: ☐ Estrogen ☐ Ogen ☐ Estrace ☐ Premarin ☐ Other (specify): _______________

☐ Progesterone ☐ Provera ☐ Other (specify): ____________

How long have you been on hormone replacement therapy (if applicable)? _____________

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?
☐ Yes ☐ No ☐Not applicable

Any other concerns:

☐ Breast cysts/lumps
☐ Breast tenderness
☐ Ovarian cysts
☐ Poor sex drive/libido
☐ Endometriosis
☐ Fibroids
☐ Infertility
☐ Vaginal discharge
☐ Vaginal odor
☐ Vaginal itch
☐ Vaginal pain
☐ PMS
☐ Menstrual cramps
☐ Heavy periods
☐ Irregular periods
☐ No periods
☐ Scanty periods
☐ Spotting between
☐ Others:

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Mental Health History

Do you have any of the following symptoms currently or in the past. Indicate c for current, p for past

_____Thoughts of harming yourself

_____Thoughts of harming others

_____Self-injurious behaviors (i.e. cutting, burning, etc.)

_____Alcohol abuse or dependence

_____Recreational drug use

_____Psychosis

_____Periods of mania

If yes to any of the above, please comment further below. Include dates that you experienced symptoms as well as treatments:

Have you ever been hospitalized for psychiatric reasons? ☐ **Yes** ☐ **No**

Total number of inpatient hospitalizations _____

If so, please list the dates, location, and reasons for all hospitalizations:

Have you ever been treated in a day or partial program? ☐ **Yes** ☐ **No**

If so, please list the dates, locations, and reasons for all treatment programs:

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Additional Space

Please send copies of any evaluations, consultations, laboratory tests, vaccinations, and any other information you feel is important for us to review.

Please use this space to describe anything else you would like us to know about you. List any other history, pertinent thoughts, or question that you would like to address:

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