|  |  |
| --- | --- |
| Functional Medicine New Patient Form |  |

# Instructions

Please take the time to fill out this form carefully. The more honest you are with your current health, the better we can personalize your care. If you have available, we need a year of any laboratory test results.

# General Information

|  |
| --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *First Middle Last* |
| Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DOB: \_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Genetic Background   |  |  |  |  | | --- | --- | --- | --- | | * African | * European | * Native American | * Caucasian | | * Asian | * Ashkenazi Jew | * Middle Eastern | * \_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| |  |  |  |  | | --- | --- | --- | --- | | Highest Education Level | * High School | * Under-Graduate | * Post-Graduate | |
| Job Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nature of Business:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Address  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Number, Street*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *City State Zip* |
| Alternative Address  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Number, Street*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *City State Zip* |
| |  |  | | --- | --- | | Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |
| Emergency Contact:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Name Relationship*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Phone Number* |
| Primary Care Physician:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Name Phone and Fax Number* |
| Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Functional Medicine New Patient - Form Page 2**

# Allergies / Sensitivities

|  |  |
| --- | --- |
| Medication/Supplement/Food | Reaction |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# Complaints / Concerns

What do you hope do you hope to achieve in your visit with us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you had a magic wand & could erase three problems, what would they be?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time you felt well? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did something trigger your change in health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What make you feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes you feel better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list current & ongoing problems in order of priority:

Fair

Good

Excellent

Mild

Moderate rate

Severerate

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Describe Problem** |  |  |  | **Prior Treatment/Approach** |  |  |  |
| *Example: Post Nasal Drip* |  | X |  | *Example: Elimination Diet* | X |  |  |
|  |  |  |  |  |  |  |  |
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**Functional Medicine New Patient - Form Page 3**

# Medical History

**DISEASES / DIAGNOSIS / CONDITIONS** - *Check appropriate box & provide date of onset*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Past* | *Ongoing* |  | *Date of Onset* |  | *Past* | *Ongoing* |  | *Date of Onset* |
|  |  | **GASTROINTESTINAL** |  |  |  |  | **GENITAL & URINARY SYSTEM** |  |
|  |  | Irritable Bowel Syndrome |  |  |  |  | Kidney Stones |  |
|  |  | Inflammatory Bowel Disease |  |  |  |  | Gout |  |
|  |  | Crohn’s |  |  |  |  | Interstitial Cystitis |  |
|  |  | Ulcerative Colitis |  |  |  |  | Frequent Urinary Tract Infections |  |
|  |  | Gastritis or Peptic Ulcer Disease |  |  |  |  | Frequent Yeast Infections |  |
|  |  | GERD (reflux) |  |  |  |  | Erectile Dysfunction |  |
|  |  | Celiac Disease |  |  |  |  | Sexual Dysfunction |  |
|  |  | Other: |  |  |  |  | Other: |  |
|  |  | **CARDIOVASCULAR** |  |  |  |  | **MUSCULOSKELETAL/PAIN** |  |
|  |  | Heart Attack |  |  |  |  | Osteoarthritis |  |
|  |  | Other Heart Disease |  |  |  |  | Fibromyalgia |  |
|  |  | Stroke |  |  |  |  | Chronic Pain |  |
|  |  | Elevated Cholesterol |  |  |  |  | Other: |  |
|  |  | Arrhythmia (irregular heart rate) |  |  |  |  | **INFLAMMATORY/AUTOIMMUNE** |  |
|  |  | Hypertension (high blood pressure) |  |  |  |  | Chronic Fatigue Syndrome |  |
|  |  | Rheumatic Fever |  |  |  |  | Autoimmune Disease |  |
|  |  | Mitral Valve Prolapse |  |  |  |  | Rheumatoid Arthritis |  |
|  |  | Other: |  |  |  |  | Lupus SLE |  |
|  |  | **METABOLIC/ENDOCRINE** |  |  |  |  | Immune Deficiency Disease |  |
|  |  | Type 1 Diabetes |  |  |  |  | Herpes-Genital |  |
|  |  | Type 2 Diabetes |  |  |  |  | Severe Infectious Disease |  |
|  |  | Hypoglycemia |  |  |  |  | Food Allergies |  |
|  |  | Metabolic Syndrome  (Insulin Resistant or Pre-Diabetes) |  |  |  |  | Poor Immune Function  (frequent infections) |  |
|  |  | Hypothyroidism (low) |  |  |  |  | Environmental Allergies |  |
|  |  | Hyperthyroidism (overactive) |  |  |  |  | Multiple Chemical Sensitivities |  |
|  |  | Endocrine Problems |  |  |  |  | Latex Allergy |  |
|  |  | Polycystic Ovary Syndrome |  |  |  |  | Other: |  |
|  |  | Infertility |  |  |  |  | **RESPIRATORY DISEASES** |  |
|  |  | Weight Gain |  |  |  |  | Asthma |  |
|  |  | Weight Loss |  |  |  |  | Chronic Sinusitis |  |
|  |  | Frequent Weight Fluctuation |  |  |  |  | Bronchitis |  |
|  |  | Bulimia |  |  |  |  | Emphysema |  |
|  |  | Anorexia |  |  |  |  | Pneumonia |  |
|  |  | Binge Eating Disorder |  |  |  |  | Tuberculosis |  |
|  |  | Night Eating Disorder |  |  |  |  | Sleep Apnea |  |
|  |  | Eating Disorder (non-specific) |  |  |  |  | Other: |  |
|  |  | Other: |  |  |  |  | **SKIN DISEASES** |  |
|  |  | **CANCER** |  |  |  |  | Eczema |  |
|  |  | Lung Cancer |  |  |  |  | Psoriasis |  |
|  |  | Breast Cancer |  |  |  |  | Acne |  |
|  |  | Colon Cancer |  |  |  |  | Melanoma |  |
|  |  | Ovarian Cancer |  |  |  |  | Skin Cancer |  |
|  |  | Prostate Cancer |  |  |  |  | Other: |  |
|  |  | Skin Cancer |  |  |  |  |  |  |
|  |  | Other: |  |  |  |  |  |  |

**Functional Medicine New Patient - Form Page 4**

# Medical History (continued)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Past* | *Ongoing* |  | *Date of Onset* |  | *Past* | *Ongoing* |  | *Date of Onset* |
|  |  | **NEUROLOGICAL** |  |  |  |  | Mild Cognitive Impairment |  |
|  |  | Depression |  |  |  |  | Memory Problems |  |
|  |  | Anxiety |  |  |  |  | Parkinson’s Disease |  |
|  |  | Bipolar Disorder |  |  |  |  | Multiple Sclerosis |  |
|  |  | Schizophrenia |  |  |  |  | ALS |  |
|  |  | Headaches |  |  |  |  | Seizures |  |
|  |  | Migraines |  |  |  |  | Other: |  |
|  |  | ADD / ADHD |  |  |  |  |  |  |
|  |  | Autism |  |  |  |  |  |  |

**PREVENTATIVE TESTS AND SURGERIES**

**DATE OF LAST TEST** Check box if yes and provide date of surgery

|  |  |  |
| --- | --- | --- |
|  | *Surgery* | *Date* |
|  | Appendectomy |  |
|  | Hysterectomy +/- Ovaries |  |
|  | Gall Bladder |  |
|  | Hernia |  |
|  | Tonsillectomy |  |
|  | Dental Surgery |  |
|  | Joint Replacement – Knee/Hip |  |
|  | Heart Surgery – Bypass Valve |  |
|  | Angioplasty or Stent |  |
|  | Pacemaker |  |
|  | Other: |  |
|  | None |  |

Check box if yes and provide date

|  |  |  |
| --- | --- | --- |
|  | *Test* | *Date* |
|  | Full Physical Exam |  |
|  | Bone Density |  |
|  | Colonoscopy |  |
|  | Cardiac Stress Test |  |
|  | EBT Heart Scan |  |
|  | EKG |  |
|  | Hemoccult Test-stool test for blood |  |
|  | MRI |  |
|  | CT Scan |  |
|  | Upper Endoscopy |  |
|  | Upper GI Series |  |
|  | Ultrasound |  |

**INJURIES BLOOD TYPE**

|  |  |
| --- | --- |
|  | Back Injury |
|  | Neck Injury |
|  | Head Injury |
|  | Broken Bones |
|  | Other: |

|  |  |
| --- | --- |
|  | A |
|  | AB |
|  | Rh+ |
|  | B |
|  | O |
|  | Unknown |

**HOSPITALIZATION**   None

|  |  |
| --- | --- |
| *Date* | *Reason* |
|  |  |
|  |  |
|  |  |
|  |  |
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**COMMENTS**

**Functional Medicine New Patient - Form Page 5**

# Gynecologic History (for women only)

**OBSTETRIC HISTORY** *Check box if yes and provide number of*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Pregnancies\_\_\_\_\_\_\_\_\_ |  | Caesarean\_\_\_\_\_\_\_\_\_\_ |  | Vaginal Deliveries\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  | Miscarriage\_\_\_\_\_\_\_\_\_\_ |  | Abortion\_\_\_\_\_\_\_\_\_\_\_\_ |  | Living Children\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  | Post-Partum Depression |  | Toxemia |  | Gestational Diabetes |  |  |
|  | Breast Feeding for how long? |  | Baby Over 8 Pounds |  |  |  |  |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |

**MENSTRUAL HISTORY**

Age at First Period: \_\_\_\_\_\_\_\_\_\_ Menses Frequency: \_\_\_\_\_\_\_\_\_\_ Length: \_\_\_\_\_\_\_\_\_\_ Pain:  Yes  No Clotting:  Yes  No

Has your period ever skipped: \_\_\_\_\_\_\_\_\_\_ For how long?: \_\_\_\_\_\_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_

Use of hormonal contraception such as:  Birth Control Pills  Patch  Nuva Ring How long? \_\_\_\_\_\_\_\_\_\_

Do you use contraception?  Yes  No  Condom  Diaphragm  IUD  Partner Vasectomy

**WOMEN’S DISORDERS / HORMONAL IMBALANCES**

 Fibrocystic Breasts  Endometriosis  Fibroids  Infertility  Painful Periods  Heavy Periods  PMS

Last Mammogram: \_\_\_\_\_\_\_\_\_\_ Breast Biopsy/Date: \_\_\_\_\_\_\_\_\_\_

Last PAP Test: \_\_\_\_\_\_\_\_\_\_  Normal  Abnormal

Last Bone Density: \_\_\_\_\_\_\_\_\_\_ Results:  High  Abnormal  Within Normal Range

Are you in Menopause? : \_\_\_\_\_\_\_\_\_\_  Yes  No Age at Menopause: \_\_\_\_\_\_\_\_\_\_

 Hot Flashes  Mood Swings  Concentration/Memory Problems  Vaginal Dryness  Decreased Libido  Heavy Bleeding

 Joint Pains  Headaches  Weight Gain  Loss of Control of Urine  Palpitations

 Use of hormone replacement therapy How long? \_\_\_\_\_\_\_\_\_\_

# Men’s History (for men only)

Have you had a PSA done?  Yes  No

PSA Level: \_\_\_\_\_\_\_\_\_\_  0-2  2-4  4-10  >10

 Prostate Enlargement  Prostate Infection  Change in Libido  Impotence  Difficulty Obtaining an Erection

 Difficulty Maintaining an Erection  Nocturia (urination at night) How many times at night? \_\_\_\_\_\_\_\_\_\_

 Urgency/Hesitancy/Change in Urinary Stream  Loss of Control of Urine

**Functional Medicine New Patient - Form Page 6**

# GI History

Foreign Travel  Yes  No Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Wilderness Camping  Yes  No Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had severe:  Gastroenteritis  Diarrhea

Do you feel like you digest your food well?  Yes  No

Do you feel bloated after meals?  Yes  No

# Patient Birth History

 Term  Premature

Pregnancy Complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Breast Fed How long? \_\_\_\_\_\_\_\_\_\_  Bottle Fed

Age at introduction of: Solid Foods: \_\_\_\_\_\_\_\_\_\_ Dairy: \_\_\_\_\_\_\_\_\_\_ Wheat: \_\_\_\_\_\_\_\_\_\_

Did you eat a lot of candy or sugar as a child?  Yes  No

# Dental History

 Silver Mercury Fillings How Many? \_\_\_\_\_\_\_\_\_\_

 Gold Fillings  Root Canals  Implants  Tooth Pain  Bleeding Gums  Gingivitis  Problem with Chewing

Do you floss regularly?  Yes  No

**Functional Medicine New Patient - Form Page 7**

# Medications

**CURRENT MEDICATIONS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Medication* | *Dose* | *Frequency* | *Start Date (month/year)* | *Reason For Use* |
|  |  |  |  |  |
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**PREVIOUS MEDICATIONS *(Last 10 years)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Medication* | *Dose* | *Frequency* | *Start Date (month/year)* | *Reason For Use* |
|  |  |  |  |  |
|  |  |  |  |  |
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**NUTRITIONAL SUPPLEMENTS (VITAMINS / MINERALS / HERBS / HOMEOPATHY)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Medication* | *Dose* | *Frequency* | *Start Date (month/year)* | *Reason For Use* |
|  |  |  |  |  |
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Have your medications or supplements ever caused unusual side effects or problems?  Yes  No

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?  Yes  No

Have you had prolonged use of Tylenol?  Yes  No

Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.)?  Yes  No

Frequent antibiotics?  Yes  No Long term antibiotics?  Yes  No

Use of steroids (prednisone, nasal allergy inhalers) in the past?  Yes  No

Use of oral contraceptives?  Yes  No

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# Family History

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Check all family members that apply* |  | Father | Brother(s) | Sister(s) | Children | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Aunt | Uncle | Other |
| Age (if still alive) |  |  |  |  |  |  |  |  |  |  |  |  |
| Age at death (if deceased) |  |  |  |  |  |  |  |  |  |  |  |  |
| Cancers |  |  |  |  |  |  |  |  |  |  |  |  |
| Colon Cancer |  |  |  |  |  |  |  |  |  |  |  |  |
| Breast or Ovarian Cancer |  |  |  |  |  |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |  |  |  |  |  |
| Hypertension |  |  |  |  |  |  |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |  |  |  |
| Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis) |  |  |  |  |  |  |  |  |  |  |  |  |
| Inflammatory Bowel Disease |  |  |  |  |  |  |  |  |  |  |  |  |
| Multiple Sclerosis |  |  |  |  |  |  |  |  |  |  |  |  |
| Auto Immune Disease (such as Lupus) |  |  |  |  |  |  |  |  |  |  |  |  |
| Irritable Bowel Syndrome |  |  |  |  |  |  |  |  |  |  |  |  |
| Celiac Disease |  |  |  |  |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |  |  |  |  |
| Exzema/Psoriasis |  |  |  |  |  |  |  |  |  |  |  |  |
| Food Allergies, Sensitivities or Intolerances |  |  |  |  |  |  |  |  |  |  |  |  |
| Environmental Sensitivities |  |  |  |  |  |  |  |  |  |  |  |  |
| Dementia |  |  |  |  |  |  |  |  |  |  |  |  |
| Parkinson’s |  |  |  |  |  |  |  |  |  |  |  |  |
| ALS or other Motor Neuron Diseases |  |  |  |  |  |  |  |  |  |  |  |  |
| Genetic Disorders |  |  |  |  |  |  |  |  |  |  |  |  |
| Substance Abuse (such as alcoholism) |  |  |  |  |  |  |  |  |  |  |  |  |
| Psychiatric Disorders |  |  |  |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |  |  |  |
| Schizophrenia |  |  |  |  |  |  |  |  |  |  |  |  |
| ADHD |  |  |  |  |  |  |  |  |  |  |  |  |
| Autism |  |  |  |  |  |  |  |  |  |  |  |  |
| Bipolar Disease |  |  |  |  |  |  |  |  |  |  |  |  |

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# Social History

**NUTRITION HISTORY**

Have you ever had a nutritional consultation?  Yes  No

Have you made any changes in your eating habits because of your health?  Yes  No Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently follow a special diet or nutritional program?  Yes  No

*Check all that apply:*

 Low Fat  Low Carbohydrate  High Protein  Low Sodium  Diabetic  No Dairy  No Wheat

 Gluten Restricted  Vegetarian  Vegan  Ultrametabolism

 Specific Program for Weight Loss / Maintenance Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height (feet/inches) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Usual Weight Range + / - 5 lbs \_\_\_\_\_\_\_\_\_\_ Desired Weight Range + / - 5 lbs \_\_\_\_\_\_\_\_\_\_

Highest Adult Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lowest Adult Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight Fluctuations (> 10lbs)  Yes  No Body Fat % \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you weight yourself?  Daily  Weekly  Monthly  Rarely  Never

Have you ever had your metabolism (resting metabolic rate) checked?  Yes  No If yes, what was it? \_\_\_\_\_\_\_\_\_\_

Do you avoid any particular foods?  Yes  No If yes, types and reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you could only eat a few foods a week, what would they be? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you grocery shop?  Yes  No If no, who does the shopping? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you like to grocery shop?  Yes  No Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you read food labels?  Yes  No

Do you cook?  Yes  No If no, who does the cooking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you like to cook?  Yes  No Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many meals do you eat out per week?  0-1  1-3  3-5  >5 meals per week

Which types of food are you concerned about when it comes to your waistline?  Sugar  Fat  Carbs  Protein

What do you feel guilty about eating?  Too much sugar  Too many carbs  Too much fat

Which one statement best describes your relationship with sugar?

 I’d like to reduce my sugar intake  I use sugar sparingly  I eat as much sugar as I want

 I’ve already “broken up” with sugar  I need to quit sugar

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# Social History cont.

**Check all the factors that apply to your current lifestyle and eating habits:**

|  |  |
| --- | --- |
| * Fast eater | * Love to eat |
| * Erratic eating pattern | * Eat because I have to |
| * Eat too much | * Have a negative relationship to food |
| * Late night eating | * Struggle with eating issues |
| * Dislike healthy food | * Emotional eater (eat when sad, lonely, depressed or bored) |
| * Time constraints | * Eat too much under stress |
| * Eat more than 50% meals away from home | * Eat too little under stress |
| * Travel frequently | * Don’t care to cook |
| * Non-availability of healthy foods | * Eating in the middle of the night |
| * Do not plan meals or menus | * Confused about nutrition advice |
| * Reliance on convenience items | * Have issues with textures of food |
| * Poor snack choices | * Crave or eat too many foods containing sugar |
| * Significant other or family members don’t like healthy foods | * Significant other or family members have special dietary needs or food preferences |

**Are you experiencing any of the following symptoms related to nutritional deficiencies:**

|  |  |
| --- | --- |
| * Stiff, sore joints | * Does not tolerate exercise |
| * Headache | * Increased secretions in mouth / nose / eyes |
| * Heartburn | * Decreased secretions in mouth / nose / eyes |
| * Gas Pain – Bloating | * Water loss (dehydration) |
| * Constipation - Diarrhea | * Inability to concentrate |
| * Anxiety - Irritability | * Muscle cramps during exercise |
| * Restlessness - Insomnia | * Muscle weakness |
| * Depression | * Easily startled |
| * Edema - hands and feet | * Loss of energy or fatigue |
| * Cold hands and feet | * Dry Skin |
| * Muscle cramps at night | * Tremors |
| * Menstrual cramps | * Inability to control blood pressure |
| * Bleeding gums | * Eyes to not tolerate changes in brightness of light well |

The most important thing I should change about my diet to improve my health is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The most important thing I feel I need help with my diet is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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