FAMILY TO FAMILY
Your Home for Whole Health Care

New Patient Packet

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WHAT TO EXPECT FROM YOUR VISIT

Welcome ! I look forward to getting to know you and working together. Please see the information below to get an idea of what to expect during your initial appointment.

PREPARATION

- There is nothing like hearing about you from you, in person. However, when I have a little familiarity with you before your visit then we can make the most of our time together.
- Please fill out our lengthy health assessment form, medical symptoms questionnaire (MSQ) and food diary as thoroughly and honestly as you can. Thank – you for taking the time to do this.
- I will review this information before your visit provided it is received 48 hours before your appointment.
- Medical records will also be reviewed if they are received in advance. Please make arrangements using the attached medical release form.
- Please contact my assistant before your visit to ensure I have received everything needed in preparation for your visit or if you have further questions. info@familytofamily.org

CHECK IN – 15 minutes before your appointment time

- This will allow you to get oriented to our office and staff and go over any paperwork.

INTEGRATIVE FUNTIONAL MEDICAL CONSULTATION with Dr. Lichtig

- Your initial visit will be scheduled for 1 - 2 hours depending on your situation and what is needed. I work with you to get to the roots of imbalance by listening and calling upon various tools and perspectives. During your visit we may explore things further from your health questionnaire. I may prescribe medication, herbs, food or supplements. I may offer guidance or counsel or simply listen and help you clarify your situation. I may do a physical exam, depending on what's needed. I may suggest nutritional changes, lifestyle modification, further testing or referral. I am here to help guide you in the next step in your process of discovery and healing. We will come up with a treatment plan together.
- I will do my best to address your needs within the scheduled time. If less time is needed you will not be charged for the full amount. If it seems that more time is needed, I may offer to extend the current visit for an additional fee or I may recommend a follow up visit to address things further.
- While I will do my best to write up a treatment plan during our visit, I also encourage you to take notes.
- Once our initial consultation is completed, follow up visits can be scheduled for 15 - 60 minutes as needed. Typically, a follow up visit is scheduled 1-3 months after your initial visit to go over lab tests or reassess how you are doing on the treatment plan. These visits are best done in person but arrangements can be made for Skype, email or phone.

CHECK OUT

You will check out with the receptionist who will assist with the following:

- Process payment for your visit.
- Schedule any follow up visits.
- Assist with purchasing or ordering supplements.

And then, my clinic assistant who will

- Arrange for labs, X-rays, referrals.
- Clarify treatment recommendations. (although it is best done with me during your visit or by email)

HEALTH ASSESSMENT/REGISTRATION FORM

Please fill out this form as completely as you can. Send it in at least **48 hrs before your appointment along with any additional medical records.** This helps me prepare for our visit, so we can spend our time focusing on what is most relevant.

LEGAL NAME: _____
NICKNAME: _____
ADDRESS: _____
_____
PHONE: home_____**cell** _____
EMAIL: _____
EMERGENCY CONTACT: _____
_____
DATE OF BIRTH:_____**AGE:**_____
REFERRED BY:_____

I have read the care agreement given to me with this packet and agree to the policies explained in that agreement. I give permission for Dr. Lichtig or her staff to contact me by phone or non-encrypted email. I request medical advice and/or treatment from Dr. Lichtig. I agree to pay in full at the time of service. I understand that non-standard therapies may be offered.
_____*(signature)*_____ *(date)*

BIG OVERVIEW

What do you hope to achieve during your visit today?
_____
_____
_____
_____

If you had a magic wand and could erase three problems, what would they be?
1. _____
2. _____
3. _____

When was the last time you felt well?
_____
_____

CURRENT CONCERNS

What is your main health concern?
_____
_____
_____
_____
_____

When did you first become aware of the main problem?

What else was happening in your life in the year before the main problem became a concern?

To what extent does this interfere with daily activities?

What may aggravate the problem (activities, positions, weather, time of day, situations, etc.)?

What if anything seems to relieve or improve the problem?

List the health care practitioners you have seen for this?

What tests and X-rays were done (if any)?

What did they think the problem was?

What treatments were prescribed or have you tried on your own? And they helped?

Please list other health concerns about your health that are also important to you.
_____
_____

OTHER HEALTH PROVIDERS

In general, are you currently working with any other physicians, doctors, coach, counselors, healers, etc?
☐No ☐ Yes Please List:

_____
_____
_____
_____
_____

FAMILY HEALTH HISTORY

Please list health history of your family members. Use * if the person is not related biologically to you though their health may have influenced you nonetheless. List age when they died.

Consider these categories:
heart, high blood pressure, stroke, cancer – type?, diabetes, asthma, kidney dz, thyroid, autoimmune, osteoporosis, depression/anxiety, alcohol/drugs, eczema, parkinsons, genetic disorders, adhd, abuse, bipolar, digestive issues, trauma, suicide.

Mother_____
Father _____
Adoptive Parents_____
Paternal GF_____
Paternal GM_____
Maternal GF_____
Maternal GM_____
Aunts/ Uncles_____
Siblings _____
Children _____

SOCIAL HISTORY

ROLES/RELATIONSHIP

Sexual preference: ☐ Men ☐ Women ☐ Both
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long term partnership ☐ Widow
Name of Partner_____
Are you satisfied with your sex life? ☐Yes ☐ No

List Children: Full Name	Age	Gender

Current people/pets in your household? # _____

Names/relationship w/ you :

_____
_____
_____

Who was in your house growing up? # _____
Names/relationship w/ you (include animals):

_____
_____
_____

Current resources for emotional support?
Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Pets ☐ Religious/Spiritual ☐ Other:_____

EDUCATION

What is the highest grade in school completed? _____
Degree, Date, Place (if applicable)

_____

WORK

Occupation _____
Current Employment

_____
Do you like your current work? ☐No ☐ Yes
Past Employment

_____
Volunteer work ☐No ☐ Yes, type,

_____

ROOTS

Where did you grow up? _____

LIFESTYLE HISTORY

FOOD AND NUTRITION HISTORY

Ever made changes in eating? ☐ No ☐Yes
Describe:_____

Do you currently follow a special diet? ☐ No ☐Yes
☐ Low Fat ☐ Low Carb ☐ High Protein
☐ Low Sodium ☐ Diabetic ☐ No Dairy
☐ No Wheat ☐ Gluten free ☐ Vegetarian
☐ Vegan ☐ Paleo ☐ Blood Type
☐ Weight loss ☐Other_____

Avoid any foods? ☐ No ☐Yes Type?_____

How often do you weigh yourself?
☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

Have you ever had your resting metabolic rate checked?
☐ No ☐Yes If yes = _____
Current Weight = _____
Desired Weight = _____
Highest Weight = _____
Lowest Weight = _____
Height = _____

Do you grocery shop? ☐Yes ☐ No, who shops? _____
Do you read food labels? ☐Yes ☐ No
Do you cook? ☐Yes ☐ No If no, who cooks? _____
Do you like to cook? ☐Yes ☐ No
meals you eat out /week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ > 5
Ever had a nutrition consultation? ☐Yes ☐ No

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

☐	Fast eater
☐	Erratic eating pattern
☐	Eat too much – portion control is an issue
☐	Late night eating
☐	Dislike healthy food
☐	Time constraints
☐	Eat more than 50% meals away from home
☐	Travel frequently
☐	Non-availability of healthy foods
☐	Do not plan meals or menus
☐	Reliance on convenience items
☐	Poor snack choices
☐	Family members don't like healthy foods
☐	Family members have special food preferences
☐	Cost of healthy food is an issue
☐	Love to eat
☐	Eat because I have to
☐	Have a negative relationship to food
☐	Struggle with eating issues
☐	Emotional eater (eat when lonely, depressed, bored)
☐	Eat too much under stress
☐	Eat too little under stress
☐	Don't care to cook
☐	Eating in the middle of the night
☐	Confused about nutrition advice

- The most important thing I <u>need</u> to change about my diet to improve my health is:

  _____

TOBACCO
Currently smoke cigarettes? ☐ No ☐Yes
#/day_____ # years_____
Cigars? ☐ No ☐Yes # years_____
Smokeless tobacco? ☐ No ☐Yes # years_____
Attempts to quit:_____
Previous Smoking: #/day____ # years___ Quit date ___
Second Hand Smoke Exposure: ☐ No ☐Yes

ALCOHOL INTAKE
Drinks/week? ☐ None, ☐ 1-3, ☐ 4-6, ☐ 7-10, ☐ > 10
Previous alcohol intake? ☐ None ☐ Mild ☐ Mod ☐High
During pregnancy? ☐ Yes ☐ No
Ever been told you should **cut down**? ☐Yes ☐ No
Do you get **annoyed** when asked about drinking? ☐Y ☐N
Ever feel **guilty** about your consumption? ☐Yes ☐ No
Do you ever take an **eye-opener**? ☐Yes ☐ No
Do you notice a tolerance to alcohol? ☐Yes ☐ No
Have you ever blacked out drinking? ☐Yes ☐ No
Do you get into arguments when drinking? ☐Yes ☐ No
Ever thought about getting help w drinking? ☐Yes ☐ No

OTHER SUBSTANCES
Caffeine: ☐ No ☐Yes | Cups/day: ☐ 1 ☐ 2-4 ☐ > 4
Sodas/ Energy drinks: ☐ No ☐Yes | ☐ 1 ☐ 2-4 ☐ > 4
List favorite type (Ex. Diet Coke, Pepsi, etc.):
_____
Are you currently using any recreational drugs? ☐ No
☐Yes , type:_____
Ever used IV or inhaled recreational drugs? ☐ No ☐Yes

EXERCISE

Activity	Type	Times/ Week	Duration Minutes
Stretching			
Cardio/Aerobics			
Strength			

Other Yoga/pilates/etc			
Sports/ Leisure Activities			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High
List problems that limit being physically active
_____
_____

Feel unusually fatigued after exercise? ☐ No ☐Yes
If yes, please describe: _____
_____
Sweat when exercising? ☐ No ☐Yes

SLEEP/REST
Avg # sleep/ night: ☐ > 10 ☐ 8-10 ☐ 6-8 ☐ < 6
Trouble falling asleep? ☐ No ☐Yes
Trouble staying asleep? ☐ No ☐Yes
Feel rested upon awakening? ☐ No ☐Yes
Do you snore? ☐ No ☐Yes
Do you use sleeping aids? ☐ No ☐Yes
Explain:_____

PSYCHOSOCIAL/SPIRITUAL
Say something about your spiritual life or connection?
_____
_____
_____
What do you like to do for fun?
_____
Feel your life has meaning and purpose? ☐Yes ☐ No
Feel less or more vital than 1 year ago? ☐Less ☐ More
Do you experience Joy? ☐Yes ☐ No

Feel you have excessive stress in your life? ☐Yes ☐ No
Feel you can easily handle stress in your life? ☐Yes ☐ No
Daily Stressors: Rate on scale of 1-10
Work_____ Family_____ Social_____
Finances_____ Health_____ Legal ___
Housing _____ Partnership _____ Time _____
Children _____ School _____ Other_____

Regular centering practice? ☐No ☐ Yes, how often?
☐ daily ☐ 4-5x/wk ☐ 2-3x/wk ☐1x/wk ☐Occasionally
Yoga_____ Breathing_____ Imagery _____
Prayer_____ Meditation_____ Tai Qi _____
Gardening_____ Other _____

Do you believe current stressor reduce the quality of your life? ☐Yes ☐ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐Yes ☐ No

Would you describe your experience as a child in your family as happy and secure? ☐Yes ☐ No
Have you experienced abuse (bullying, physical, sexual, emotional)? ☐Yes ☐ No
If yes, describe briefly._____
_____

Do you currently feel safe in your home or work environment? ☐Yes ☐ No

Have you experienced major loss in your life? ☐Yes☐ No
If yes, describe briefly._____
_____

Have you ever been a victim of a crime, or experienced a significant trauma? ☐Yes ☐ No
If yes, describe briefly._____
_____

Have you ever sought counseling? ☐Yes ☐ No
Are you currently in therapy? ☐Yes ☐ No
Describe:_____
Have you ever sought spiritual healing? ☐Yes ☐ No
Describe:_____

ENVIRONMENTAL EXPOSURES

Known adverse food reactions/sensitivities? ☐Yes ☐ No
If yes, describe symptoms and list foods:
_____
_____
Adverse reaction to caffeine? ☐Yes ☐ No
☐ Irritable or Wired ☐ Aches and Pains
Do you adversely react to *(Check all that apply)*
☐ Monosodium glutamate (MSG) ☐ Preservatives
☐ Bananas ☐ Garlic ☐ Alcohol ☐ Aspartame
☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Onion
☐ Sulfite Containing Foods (wine, dried fruit)
☐ Other:_____
Which of these significantly affect you?
☐ Cigarette Smoke ☐ Perfumes ☐ Auto Fumes
☐ Other:_____
In your work or home environment, are you exposed to:
☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold
Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? ☐Yes ☐ No
Do you have farm animals? ☐Yes ☐ No
Have you ever turned yellow (jaundiced)? ☐Yes ☐ No

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides ☐ Pesticides

☐ Heavy Metals ☐ Organic Solvents

Chemical Name, Date, Length of Exposure: _____

☐ Other_____

Do you dry clean your clothes frequently? ☐Yes ☐ No

What % do you use your seatbelt? _____

What % do you wear a bike helmet? _____

Hrs/day spent in front of a computer? _____

Hrs/day watching TV? _____

Hrs/day spent on a cell phone? _____

Do you use a headset with your cell phone? ☐Yes ☐ No

Where do you store phone when not in use? _____

Other Exposures you may be concerned about ?

_____

MEDICATIONS & SUPPLEMENTS

(bring ALL the bottles to ALL of your visits)

Name & Phone # of your Pharmacy _____

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS (if you recall last 10 yrs)

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Medications/supplements ever caused unusual side effects ☐No ☐ Yes, describe:_____

Any known Medication Allergies ☐Yes ☐ No

Describe:_____

_____

Prolonged or regular use of Aspirin or NSAIDS (Advil, Aleve, Motrin.) ☐Yes ☐ No

Prolonged use of Tylenol ☐Yes ☐ No

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) ☐Yes ☐ No

Use of oral contraceptives ☐Yes ☐ No

MEDICAL HISTORY

Past Condition	*Ongoing Condition*	***Check the box and provide approximate date of onset and age***
		NEUROLOGICAL
☐	☐	Memory Problems _____
☐	☐	Parkinsons_____
☐	☐	Multiple Sclerosis_____
☐	☐	Headaches_____
☐	☐	ADD/ADHD_____
☐	☐	ALS_____
☐	☐	Seizures_____
☐	☐	Autism_____
☐	☐	Mild Cognitive Impairment_____
☐	☐	Insomnia or sleep problems_____
☐	☐	Other _____
		GASTROINTESTINAL
☐	☐	Ulcerative Colitis_____
☐	☐	Crohn's_____
☐	☐	Celiac Disease_____
☐	☐	Gastritis or Peptic Ulcer Disease_____
☐	☐	GERD (reflux)_____
☐	☐	Irritable Bowel Syndrome (IBS) w/constipation __ diarrhea__ both___

☐	☐	Traveler's diarrhea
☐	☐	Other _____
		PSYCHOSPIRITUAL
☐	☐	Anxiety _____
☐	☐	Depression _____
☐	☐	Bipolar _____
☐	☐	PTSD _____
☐	☐	Schizophrenia _____
☐	☐	Nightmares _____
☐	☐	Other _____
		CARDIOVASCULAR
☐	☐	Stroke_____
☐	☐	Elevated Cholesterol_____
☐	☐	Arrhythmia (irregular heart rate)_____
☐	☐	Hypertension (high blood pressure)_____
☐	☐	Rheumatic Fever_____
☐	☐	Mitral Valve Prolapse_____
☐	☐	Heart Attack _____
☐	☐	Other _____
		OTHER
☐	☐	

☐	☐	Environmental Allergies_____
☐	☐	Multiple Chemical Sensitivities_____
☐	☐	Latex Allergy_____
☐	☐	Other _____
		RESPIRATORY
☐	☐	Asthma_____
☐	☐	Chronic Sinusitis_____
☐	☐	Bronchitis_____
☐	☐	Emphysema_____
☐	☐	Pneumonia_____
☐	☐	Tuberculosis_____
☐	☐	Sleep Apnea_____
☐	☐	Other _____
		SKIN
☐	☐	Eczema_____
☐	☐	Psoriasis_____
☐	☐	Acne_____
☐	☐	Moles_____
☐	☐	
☐	☐	

Past Condition	*Ongoing Condition*	**GENITAL AND URINARY SYSTEM**
☐	☐	Kidney Stones_____
☐	☐	Gout_____
☐	☐	Interstitial Cystitis_____
☐	☐	Frequent Urinary Tract Infections_____
☐	☐	Frequent Yeast Infections_____
☐	☐	Sexual Dysfunction_____
☐	☐	Other _____
		MUSCULOSKELETAL/PAIN
☐	☐	Osteoarthritis_____
☐	☐	Fibromyalgia_____
☐	☐	Chronic Pain_____
☐	☐	Other _____
		INFLAMMATORY/AUTOIMMUNE
☐	☐	Chronic Fatigue Syndrome_____
☐	☐	Autoimmune Disease_____
☐	☐	Rheumatoid Arthritis_____
☐	☐	Lupus SLE_____
☐	☐	Immune Deficiency Disease_____
☐	☐	Herpes-Genital_____
☐	☐	Severe Infectious Disease_____
☐	☐	Poor Immune Function_____
☐	☐	Food Allergies_____

Past Condition	*Ongoing Condition*	***Check the box and provide approximate date of onset and age***
		METABOLIC/ENDOCRINE
☐	☐	Type 1 Diabetes_____
☐	☐	Type 2 Diabetes_____
☐	☐	Hypoglycemia_____
☐	☐	Metabolic Syndrome_____
☐	☐	Hypothyroidism (low thyroid)_____
☐	☐	Hyperthyroidism (overactive thyroid)_____
☐	☐	Eating Disorder (non-specific)_____
☐	☐	Polycystic Ovarian Syndrome (PCOS)_____
☐	☐	Infertility_____
☐	☐	Obesity_____
☐	☐	Trouble losing weight _____
☐	☐	Trouble gaining Weight _____
☐	☐	Other _____
		CANCER
☐	☐	Lung Cancer_____
☐	☐	Breast Cancer_____
☐	☐	Colon Cancer_____
☐	☐	Ovarian Cancer_____
☐	☐	Prostate Cancer_____
☐	☐	Other _____
☐	☐	

BLOOD TYPE:			
☐	**A**	☐	**B**
☐	**AB**	☐	**O**
☐	**Rh+**	☐	**Unknown**

HOSPITALIZATIONS ☐ **None**

Date/ age	*Reason*

IMMUNIZATION HISTORY

Last TDAP?_____ Flu shot?_____Hep B _____

Other shots? _____

DIAGNOSTIC TESTS
Check box if yes and provide most recent date and age you were
Full Physical Exam_____
Upper Endoscopy_____
Colonoscopy_____
Cardiac Stress Test_____
EKG_____
Mammogram_____
Bone Density_____
Pap or Pelvic exam _____
CT Scan_____
Chest xray_____
Lab Tests _____
Other _____

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy_____
- ☐ Hysterectomy +/- Ovaries_____
- ☐ Gall Bladder_____
- ☐ Hernia_____
- ☐ Tonsillectomy_____
- ☐ Dental Surgery_____
- ☐ Joint Replacement _____
- ☐ Heart Surgery - Bypass Valve_____
- ☐ Angioplasty or Stent_____
- ☐ Pacemaker_____
- ☐ Other_____
- ☐ **None**

INJURIES *provide age that you were.*			
☐	Back Injury	☐	Head Injury
☐	Neck Injury	☐	Broken Bones
☐	Other_____		

PREGNANCY HISTORY

Date & your age	*V= Vaginal C= Cesarean M=miscarriage T = therapeutic abortion S = Stillbirth*	*Birth weight*	*Boy or Girl*	*Home or Hosp or Birth center*	**DETAILS (see key)**

Details Key for Pregnancy History

JOY = joyful experience

PRE = Pre-eclampsia

GDM = Gestational Diabetes

SROM = Bag of water broke on its own "spontaneously"

IND = induction

PPH = bled a lot after birth

SD = Baby's shoulders were tight during birth, "dystocia"

NICU = baby spend time in NICU

EPI = had epidural

GBS = Group B strep positive

ABX = received antibiotics during labor

VAVD = birth of baby's head assisted with forceps or suction cup aka "vacuum"

PPD = Post-Partum Depression

BF = breastfed

TR = pregnancy, birth or post partum left me traumatized

CBE = attended childbirth classes

DA = worked with a doula

COMP = other complication not listed here

X = other detail not listed here

What stands out to you in each of your pregnancy, birth and post partum experiences

YOUR BIRTH AND INFANCY

☐ Full Term ☐ Premature ☐ Cesarean ☐ Vaginal

Say something about your mom's pregnancy/birth w/ you.

☐ Breast Fed How long?_____

Age at introduction of solid foods:_____

Any food sensitivities during infancy?_____

Developmental Delays (ages)?_____

Hospitalizations as an infant under age 2?

Antibiotics under age 5?

How were you described as an infant?

GYNECOLOGIC PAST HISTORY

MENSTRUAL HISTORY

Age at First Period:_____
Ever skipped? ☐No ☐ Yes, how long?_____
Age at First Intercourse:_____
Which contraception have you used? ☐ Pill ☐ Patch
☐ Nuva ☐ Diaphragm ☐ IUD ☐ Vasectomy
☐ Tubal ☐ Withdrawal ☐ Rhythm
☐ Condom w/spermicide ☐ Condom without spermicide
☐ Other

IMBALANCES

Vaginal: ☐dryness ☐itching ☐discharge ☐pain ☐odor
☐infection ☐irritation ☐rash

Pelvic: ☐pain w/intercourse ☐ pain without intercourse
☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Other

Breasts: ☐ Fibrocystic ☐ Other _____
Last Mammogram:_____

Periods: ☐ Painful ☐ Heavy ☐ Absent ☐ Irregular

PMS with the following:
☐ bloating ☐ anxiety ☐ depression ☐ tender breasts

PAP: date last test /result:_____
☐ History of abnormal pap or HPV
☐ History of Colposcopy(***date and age)*** _____
☐ LEEP procedure(***date and age)*** _____

Bone Density: date last test /result:_____
☐ Osteopenia ☐ Osteoporosis ☐ Normal

Menopausal: ☐No ☐Yes, Age of LMP _____
☐No symptoms ☐Hot flashes ☐Mood Swings
☐Concentration/Memory Problems ☐Weight Gain
☐Vaginal Dryness ☐Decreased Libido ☐ Bleeding
☐Palpitations ☐Joint Pains ☐Loss of Control of Urine
☐Headaches ☐Use of hormone replacement therapy

MEN'S HEALTH PAST HISTORY

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, or ☐ Ejaculation
☐ Difficulty maintaining an Erection
☐ Nocturia (urination at night). # of times? _____
☐ Urgency/Hesitancy/Change in Urinary Stream
☐ Loss of Control of Urine

SEXUAL HEALTH HISTORY

Sexually active currently? ☐Yes ☐No
Satisfied with your sexual life? ☐Yes ☐No
Problems with sexual arousal? ☐Yes ☐No
Loss of sexual interest? ☐Yes ☐No
Excessive sexual interest? ☐Yes ☐No
Pain with intercourse? ☐Yes ☐No
History of sexual trauma? ☐Yes ☐No
History of STDs or STIs ? ☐Yes ☐No
Other sexual concerns ? □Yes □ No

ADDITIONAL COMMENTS YOU WANT TO MAKE ABOUT YOUR HEALTH HISTORY

_____

_____

_____

_____

REVIEW OF SYSTEMS - PRESENT

Check all that apply to you currently. Please circle when there are multiple options in a line.

General
Weight Loss/ Weight Gain
Night Sweats/ Flushing during day
Fatigue - General/Episodic/Chronic
No stamina with exertion
Weight Concerns - loss/gain
Swollen glands
Cold hands and feet
Low body temperature
Intolerant of Heat/Cold
Excessive Thirst
Nightmares/ Recurrent Dreams

Skin
Rashes
Moles
Warts
Lumps
Bumps on back of arms
Red skin
Easy bruising
Sweating excess/lack of
Hives
Dandruff
Cradle cap
Dry Skin
Itching anywhere
Cracking/peeling
Eczema
Sensitivity to bug bites

Sensitivity to poison ivy/oak
Shingles/herpes
Strong body odor
Athletes foot/jock itch
Lack of pigment
Acne
Skin Cancer
Hair and Naiils
Unwanted Hair/ Hair Loss
Hair coloring or permanent
Premature graying
Nails: brittle/curve up/ bitten/ thick/
frayed/fungus/spots/ridges/soft

Eyes
Glasses/Contacts
Eye pain/ blurriness/ tired/ dry/ itchy/ watery/redness
Crusting of lids
Vision – loss/ blurriness/change
Glaucoma/ Cataracts
Dark circles under eyes
Ears
Ringing/ Hearing loss
Ear pain/fullness
Chronic Ear Infections
Swimmers Ear/ Ear Wax
Sensitivity to sound

Nose & Sinus
Frequent Colds
Nose Bleeds
Hayfever /Sneezing
Congestion/Sinus Pressure/ Pain
Distorted sense of smell

Mouth & Throat
Frequent Cavities
White spots on teeth
Do you floss regularly? □Yes □ No
Silver Mercury Fillings How many? ____
Other fillings
Dentures
Root Canals/ Implants/ Extractions
Gum problems
Trouble chewing
Bad breath
Dry mouth
Cracking in corners of lips
Swollen tongue or lips
Tooth Pain
Sore Throat
Jaw click/ Teeth clenching/ Facial pain
Canker Sores/ Cold Sores
Hoarseness
Speech Problems
Distorted sense of taste
Fullness in throat

Neck
Pain/ Stiffness
Swollen lymph glands
Enlarged thyroid gland

Breast
Pain/ Lumps
Nipple Discharge
Cysts

Respiratory
Cough – productive/dry
Shortness of breath
Wheezing
Recurrent Infections
Conscious of Breathing
Breath holding

CardioVascular
Chest Pain/ Angina
Swelling of ankles or legs
Irregular Heart Beats
Heart racing
Fainting Spells
Sleep with extra pillows
Short of breath with exertion
Awaken with trouble breathing
Blood Clots
Leg pain with exercise
Poor circulation
Varicose veins
Leg Cramps @ rest/ while walking

Digestion
Poor Appetite/ Excessive Hunger
Food Allergies or sensitivities
Difficulty swallowing
Nausea/ Vomiting
Gall stones
Heartburn/ Regurgitation/Reflux/Indigestion
Cramping/ Bloating
Flatus/Gas/Burping
Upper/Lower Abdominal Pain
Jaundice
Diarrhea/ Constipation
Hemorrhoids/ Rectal Pain/ Fissures/Spasm/Itching
Frequency of stools/day_____
Abnormal appearance of stools
Bloody Stools/ Black Stools
Do you feel you digest your food well? □Yes □ No
Do you feel bloated after meals? □Yes □ No

Urinary
Frequency/ Pain/ Burning/ Urgency
Difficulty starting/stopping stream
Kidney stones

Leakage of urine/ incontinence
Wake up to urinate, # of times____
Bed Wetting

Reproductive Female
Hot flashes
Infertility
Vaginal dryness/itching/discharge/ pain/odor
Pelvic pain with intercourse/without intercourse
Periods
First day of last menstrual period _____
days of flow _____
days between cycles _____
Pain w flow: □Yes □No
Clotting w flow: □Yes □No
Heavy flow: □Yes □No
Minimal Flow: □Yes □No
PMS symptoms
Constipation/ Swelling
Moodiness/ depression/ irritability
Sore breast/ sugar cravings

Reproductive Male
Penile discharge
Scrotum pain/ lumps
Loss of erection/ ejaculation problems
Prostate problems

Neurologic
Headaches: tension/ migraine/hormonal/ food/ weather
Seizures
ADD/ADHD
Autism
Fogginess/ Difficulty concentrating
Poor memory
Trouble finding words
Trouble thinking
Trouble with balance
Tremors/ Shakiness
Loss of sensation/ numbness
Restless legs
Dizziness - fainting or almost fainting
Dizziness - spinning or vertigo

Musculoskeletal
Muscle weakness/pain
Location _____
Foot or muscle cramps
Tendonitis
Back Trouble/ Sciatica
Joint Pain/ Stiffness/ Swelling
Location _____

Psychological
Nervousness/Anxious/ Panic
Excess worry/Stress
Grief
Depression
Irritability
Thoughts of Suicide
Marital/Relationship problems
Agoraphobia
Hallucinations
Other phobias
OCD

Sleep
When do you go to sleep? _____
When do you awaken? _____
Difficulty falling asleep/Staying asleep
Difficulty going back to sleep
Recurrent dreams or Nightmares
Daytime sleepiness/ Snoring
Take anything to help you sleep? □Yes □ No
Allergies
Environmental _____
Chemical_____
Food_____
Other_____

OTHER QUESTIONS/ CONCERNS YOU WANT DR. LISA TO KNOW