

## Supplemental Questionnaire for Patients Who Want Nutritional and Hormone Programs

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### Family History

Has anyone in your family had:

Diabetes  Yes  No Relation \_\_\_\_\_  
 Thyroid Disease  Yes  No Relation \_\_\_\_\_  
 Breast or ovarian cancer  Yes  No Relation \_\_\_\_\_

### Allergies None Lactose intolerance Peanut allergy

List Drug and Reaction \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Others (food, bee stings, etc) \_\_\_\_\_  
 \_\_\_\_\_

### Medications now being taken None (Please bring all medications to your appointment!)

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Supplements now being taken None (Please bring all supplements to your appointment!)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Miscellaneous

Do you wear seatbelts? \_\_\_\_\_  Yes  No

Are there any personal problems you'd like to discuss (e.g., family or marital problems, concerns about AIDS or other diseases, or preventive health issues)? \_\_\_\_\_  Yes  No

Are you on disability? \_\_\_\_\_  Yes  No

Is litigation pending regarding a medical problem? \_\_\_\_\_  Yes  No




## Alcohol consumption

- Has there been a period when you consumed more than you presently do?  Yes  No
- Have you ever felt you ought to cut down on your drinking?  Yes  No
- Do people annoy you by criticizing your drinking?  Yes  No
- Have you ever felt guilt about your drinking?  Yes  No
- Have you ever had a drink first thing in the morning to steady your nerves or reduce a hangover?  Yes  No



## General

- Are you frequently ill?  Yes  No
- Are you having  fever  chills  sweats  Yes  No
- Recent weight - Have you  lost  gained  Yes  No
- What's the most you've weighed? \_\_\_\_\_ When? \_\_\_\_\_
- Do you have a loss of appetite?  Yes  No
- Do you have difficulty  falling  staying asleep?  Yes  No
- Are you incapable of experiencing pleasure?  Yes  No
- Do you suffer from complete exhaustion?  Yes  No
- Have you ever been treated for an emotional illness?  Yes  No
- Are you depressed?  Yes  No
- Do you have feelings of worthlessness or guilt?  Yes  No
- Do you have difficulty concentrating?  Yes  No
- Do you have recurrent thoughts of death or suicide?  Yes  No
- Are you considered a nervous person?  Yes  No



## Skin and Hair

- Have you had a  skin rash  itching?  Yes  No
- Have you had  lumps  growths  changing moles?  Yes  No
- Have you had significant changes in  hair  nails?  Yes  No
- Have you experienced skin reactions to the sun, other than sunburn?  Yes  No




## Eyes

- Have you had double vision , blurry vision , or blind spots ?  Yes  No
- Do you wear glasses  or contact lenses ?  Yes  No
- Do you have glaucoma  or cataracts ?  Yes  No
- Have you had laser treatment  or surgery  on your eyes?  Yes  No
- Have you had any eye injuries or infections?  Yes  No
- When was your last eye checkup? \_\_\_\_\_
- When was your last glaucoma test? \_\_\_\_\_



## Ears

- Do you have any current ear problems?  Yes  No
- Are you hard of hearing?  Yes  No
- Do you have ringing in the ears?  Yes  No
- When was your last hearing test? \_\_\_\_\_



## Nose and Throat

- Have you had sinus trouble?  Yes  No
- Do you have hay fever?  Yes  No
- Have you had hoarseness or change in voice?  Yes  No
- Do you have significant alteration in taste and smell?  Yes  No
- Do you have nasal polyps?  Yes  No
- Any history of radiation therapy to the face or neck?  Yes  No
- Any history of thyroid disease?  Yes  No



## Heart

- When was your last electrocardiogram? \_\_\_\_\_ Abnormal? \_\_\_\_\_  Yes  No
- Do you have any heart problems? \_\_\_\_\_  Yes  No
- Do you have high blood pressure? \_\_\_\_\_  Yes  No
- Do you have an elevated cholesterol level? \_\_\_\_\_  Yes  No
- Have you ever suffered a heart attack? If yes, when? \_\_\_\_\_  Yes  No
- Do you have any chest pain or discomfort? \_\_\_\_\_  Yes  No
- How many pillows do you sleep on? \_\_\_\_\_  Yes  No
- Are your ankles often definitely swollen? \_\_\_\_\_  Yes  No
- Are you bothered by thumping, racing or skipping of the heart? \_\_\_\_\_  Yes  No
- Have you ever been told you have a heart murmur? \_\_\_\_\_  Yes  No
- Have you ever had a blood clot or thrombophlebitis? \_\_\_\_\_  Yes  No



## Chest

- When was your last chest x-ray? \_\_\_\_\_  Yes  No
- Was it abnormal? \_\_\_\_\_  Yes  No
- Have you had asthma or wheezing? \_\_\_\_\_  Yes  No
- Do you have shortness of breath  at rest  with exertion  at night? \_\_\_\_\_  Yes  No
- Do you have a frequent cough? \_\_\_\_\_  Yes  No
- Have you ever coughed up blood? \_\_\_\_\_  Yes  No
- Have you been exposed to asbestos? \_\_\_\_\_  Yes  No



## Gastrointestinal

- Do you have trouble swallowing? \_\_\_\_\_  Yes  No
- Do you regularly have heartburn? \_\_\_\_\_  Yes  No
- Are you troubled by nausea or vomiting? \_\_\_\_\_  Yes  No
- Do you have abdominal pain? \_\_\_\_\_  Yes  No
- Have you ever been diagnosed as having  ulcer  gallbladder disease? \_\_\_\_\_  Yes  No
- Have you had any liver problems? \_\_\_\_\_  Yes  No
- Have you had hepatitis or jaundice? \_\_\_\_\_  Yes  No
- Do you have  diarrhea  constipation? \_\_\_\_\_  Yes  No
- Do you use laxatives? If yes, what? \_\_\_\_\_ How often? \_\_\_\_\_  Yes  No
- Do you have hemorrhoids or other rectal problems? \_\_\_\_\_  Yes  No
- Have you had black or bloody stools? \_\_\_\_\_  Yes  No
- When was your last sigmoidoscopic exam? \_\_\_\_\_  Yes  No
- Have you been diagnosed as having colon polyps? \_\_\_\_\_  Yes  No



## Men

- Do you have a history of prostate trouble? \_\_\_\_\_  Yes  No
- Any difficult sustaining an erection? \_\_\_\_\_  Yes  No
- Any difficult ejaculating? \_\_\_\_\_  Yes  No



## Genitourinary

- Have you been bothered by frequent urination? \_\_\_\_\_  Yes  No
- Do you wake to urinate at night? \_\_\_\_\_  Yes  No
- Are you having burning pain while urinating? \_\_\_\_\_  Yes  No
- Have you passed blood in your urine? \_\_\_\_\_  Yes  No
- Have you ever had a kidney or bladder infection? \_\_\_\_\_  Yes  No
- Have you ever had a kidney stone? \_\_\_\_\_  Yes  No
- Do you have trouble starting or stopping the urine? \_\_\_\_\_  Yes  No
- Do you sometimes lose control of your bladder? \_\_\_\_\_  Yes  No
- Have you ever had a venereal disease? If yes, what? \_\_\_\_\_  Yes  No
- Are you having any sexual problems? \_\_\_\_\_  Yes  No



### Bones and Joints

- Do you have joint pain or stiffness?  Yes  No
- Do your joints ever get  red  swollen?  Yes  No
- Do you have back pain that limits your activities?  Yes  No
- Do you have severe neck pain?  Yes  No
- Have you ever had gout?  Yes  No
- Do you have osteoporosis?  Yes  No
- Have you had hepatitis or jaundice?  Yes  No
- Do you have muscle  weakness  tenderness?  Yes  No
- Do you get muscle cramps when  walking  at night?  Yes  No



### Neurological

- Are you having frequent or severe headaches?  Yes  No
- Have you had fainting or loss of consciousness?  Yes  No
- Have you ever had a seizure or convulsion?  Yes  No
- Are you ever bothered by a spinning sensation or vertigo?  Yes  No
- Do you have a balance problem?  Yes  No
- Do you have periods of lightheadedness?  Yes  No
- Do you have difficult walking?  Yes  No
- Do you experience  numbness  tingling in your arms or legs?  Yes  No

# General Habit Questions

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Food and Drink

Check all the following habits that pertain to you now or in the recent past.

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="checkbox"/> Caffeine   | <input type="checkbox"/> Fruit juices           | <input type="checkbox"/> Artificial Sweeteners |
| <input type="checkbox"/> Alcohol    | <input type="checkbox"/> Milk/Soy milk/Ricemilk | <input type="checkbox"/> Diet Pills            |
| <input type="checkbox"/> Sodas      | <input type="checkbox"/> Sweets/Desserts        | <input type="checkbox"/> Antidepressants       |
| <input type="checkbox"/> Diet sodas |   |  |

On average, how many of each of the following beverages do you drink in a day? If not daily, in a typical week?

- |                            |                    |                        |                    |                               |  |
|----------------------------|--------------------|------------------------|--------------------|-------------------------------|--|
| Regular coffee _____       | Daily/Weekly _____ | Regular sodas _____    | Daily/Weekly _____ | Alcoholic _____               | Daily/Weekly _____   |
| Decaf coffee _____         | Daily/Weekly _____ | Diet sodas _____       | Daily/Weekly _____ | Mostly                        |  |
| Caffeinated hot tea _____  | Daily/Weekly _____ | Fruit juice _____      | Daily/Weekly _____ | <input type="checkbox"/> wine | <input type="checkbox"/> beer <input type="checkbox"/> hard liquor |
| Caffeinated iced tea _____ | Daily/Weekly _____ | Milk _____             | Daily/Weekly _____ |                               |  |
|                            |                    | Milk Substitutes _____ | Daily/Weekly _____ |                               |  |

Would you consider yourself to have a problem with alcohol?  Yes  No

On average, how many sweets/desserts do you consume in a day? \_\_\_\_\_

How many items of artificial sweetener do you use daily? \_\_\_\_\_

If you are currently taking diet pills, what are you taking? \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

## Tobacco

Check all the following habits that pertain to you.

- |   |                       |                        |                    |
|---|-----------------------|------------------------|--------------------|
| <input type="checkbox"/> Smoke cigarettes | How many years? _____ | # of packs daily _____ | In the past? _____ |
| <input type="checkbox"/> Smoke cigars     | How many a day? _____ | In a week? _____       |                    |
| <input type="checkbox"/> Nicotine gum     | How long? _____       |                        |                    |
| <input type="checkbox"/> Nicotine patches | What kind? _____      | How long? _____        |                    |
| <input type="checkbox"/> Chew tobacco     | How long? _____       |                        |                    |

Have you ever tried quitting and not been able to?  Yes  No

## Stress Index

Would you consider yourself to be under a new acute stress or a constant chronic stress?  Yes  No

If yes, check the best description(s) of your current stress.

- |   |                     |
|---|---------------------|
| <input type="checkbox"/> Family _____       | New / Chronic _____ |
| <input type="checkbox"/> Financial _____    | New / Chronic _____ |
| <input type="checkbox"/> Work-related _____ | New / Chronic _____ |
| <input type="checkbox"/> Personal _____     | New / Chronic _____ |
| <input type="checkbox"/> Illness _____      | New / Chronic _____ |
| <input type="checkbox"/> Travel _____       | New / Chronic _____ |

Do you feel you handle your stress well? \_\_\_\_\_  Yes  No

Do you wake in the middle of the night thinking about things that happened during the day? \_\_\_\_\_  Yes  No

Do you feel the stress you're under is within your control? \_\_\_\_\_  Yes  No

How many hours do you work in a day (including mothers taking care of children)? \_\_\_\_\_ How many days? \_\_\_\_\_

How many total hours do you work in a week? \_\_\_\_\_

How long do you commute to get to work? Hours \_\_\_\_\_ Minutes \_\_\_\_\_

Do you travel extensively for your work? \_\_\_\_\_  Yes  No

If the definition of stress is not having enough time to care for yourself (e.g., sleep, eating well, exercise), would you consider yourself a stressed person? \_\_\_\_\_  Yes  No



## Stress Management

Check all the items below that pertain to what you do to help handle your daily stresses.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Exercise                  | <input type="checkbox"/> Take regular vacations   | <input type="checkbox"/> See a counselor                 |
| <input type="checkbox"/> Take baths/Jacuzzi        | <input type="checkbox"/> Eat comfort food         | <input type="checkbox"/> Take medication                 |
| <input type="checkbox"/> Long walks/hikes          | <input type="checkbox"/> Talk with family/friends | <input type="checkbox"/> Play with pets                  |
| <input type="checkbox"/> Read                      | <input type="checkbox"/> Watch TV/movies          | <input type="checkbox"/> Get body work (massage, facial) |
| <input type="checkbox"/> Meditate/Yoga/other forms | <input type="checkbox"/> Sleep                    | <input type="checkbox"/> Drink alcohol                   |

Other? \_\_\_\_\_



## Exercise/Activity

Is your job  active  sedentary?

How many hours a day are you sitting down (including travel time)? \_\_\_\_\_

On average, how much time do you exercise each day?

- |                                  |  |
|----------------------------------|--|
| <input type="checkbox"/> 0 min.  | <input type="checkbox"/> 1 hour, 15min.  |
| <input type="checkbox"/> 15 min. | <input type="checkbox"/> 1 hour, 30 min. |
| <input type="checkbox"/> 30 min. | <input type="checkbox"/> 1 hour, 45 min. |
| <input type="checkbox"/> 45 min. | <input type="checkbox"/> 2 hours or more |
| <input type="checkbox"/> 1 hour  |  |

Describe what you do for exercise/activity. (Include gardening/yard work and housework.)

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

Do you think you get enough exercise on a weekly basis?  Yes  No If not, why?

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



## Diet History

Do you ever skip meals?  Yes  No

If yes, how many meals on average do you skip in a week? \_\_\_\_\_

Which of the following best describes your meal plans?

- High carbohydrate, low fat
- A balance of carbohydrates, fats, proteins, and vegetables
- Vegetarian/Vegan
- Mostly eating out and on the go
- Constantly dieting
- None of the above. Please describe: \_\_\_\_\_

Have you ever been on a diet?  Yes  No

If yes, please list every diet, including diet pills, that you have been on. (Use back of page if needed.)

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

Are you happy about your current weight?

If not, why not? \_\_\_\_\_

\_\_\_\_\_

Which of the following food or items do you crave?

- \_\_\_\_\_ Breads, pasta and other starches \_\_\_\_\_ Salt
- \_\_\_\_\_ Chocolate \_\_\_\_\_ Sweets/sugar \_\_\_\_\_ Alcohol
- \_\_\_\_\_ Other \_\_\_\_\_

Do you feel you eat enough vegetables in a day?  Yes  No

How many glasses of water do you drink in a day? \_\_\_\_\_

## Female Health History

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

1. What was your age at the time of your first period? \_\_\_\_\_
  
2. Were your periods every month?      Yes      No
  
3. Are they regular now?      Yes      No
  
4. What was the date of your last menstrual period? \_\_\_\_\_
  
5. Have you had your uterus removed?      Yes      No  
     Ovaries removed?                      Yes      No  
     If yes, when? \_\_\_\_\_ Why? \_\_\_\_\_
  
6. Did you ever use birth control pills?      Yes      No  
     For how long? \_\_\_\_\_ Are you using them now?      Yes      No
  
7. Did you ever have any fertility problems?      Yes      No
  
8. Date of last mammogram? \_\_\_\_\_ Was it normal?      Yes      No  
     If abnormal, explain: \_\_\_\_\_  
     \_\_\_\_\_
  
9. Other than noted above, have you ever had an abnormal mammogram?      Yes      No  
     If yes, explain: \_\_\_\_\_  
     \_\_\_\_\_
  
10. Do you get routine mammograms?      Yes      No  
     If no, why not? \_\_\_\_\_
  
11. Date of last PAP smear: \_\_\_\_\_ Normal?      Yes      No
  
12. Have you had a uterine ultrasound?      Yes      No
  
13. Have you had a bone mineral density study?      Yes      No  
     If yes, when? \_\_\_\_\_ Results? \_\_\_\_\_

## Female Health History (continued)

14. Do you have any history of D & C's?      Yes      No

If yes, when and why? \_\_\_\_\_

15. Are you experiencing any of the following now?

Night sweats/hot flashes	Yes	No
Heart palpitations	Yes	No
Anxiety	Yes	No
Changes in hair/skin	Yes	No
Depression	Yes	No
Sleep disturbances	Yes	No
Emotional lability	Yes	No
Vaginal dryness	Yes	No
Decreased libido	Yes	No
Frequent headaches	Yes	No
Memory or concentration problems	Yes	No

16. How many full-term pregnancies have you had? \_\_\_\_\_

17. How many miscarriages have you had? \_\_\_\_\_

18. What was the weight of your heaviest baby? \_\_\_\_\_

19. What was your weight before and after each pregnancy? \_\_\_\_\_

20. Were you able to lose the weight after each pregnancy without dieting?      Yes      No

21. Did your periods resume normally after each pregnancy?      Yes      No