Westlake Medical Arts

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ADULT MEDICAL QUESTIONNAIRE

First Name: _____ Middle Name: _____ Last Name: _____

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

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

Cell Phone: (_____) _____-_____ E-mail: _____

Place of Birth:_____ Occupation: _____

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

Today's Date _____ Emergency Contact: _____ Ph: _____

Pharmacy of choice: _____ Location: _____

Compounding pharmacy of choice: _____ Location: _____

1. **Allergies** to Environment/Food/Medications:

_____ _____

_____ _____

_____ _____

_____ _____

Medications/Supplements I Take:

Product Name	Strength	Directions
Example: Fish Oil	1000 mg	once daily

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

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

2. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)

Example: Wendy, age 7, sister

_____

_____

3. Have you ever lived or traveled outside of the United States? Yes ☐ No ☐

If so, when and where?

_____

_____

_____

4. 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 Bone (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)		

5. Hospitalizations:

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

6. Have you ever used alcohol? Yes☐ No☐

a. 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☐

d. If yes, please indicate time period (month/year): From _____ To _____.

7. Have you ever used recreational drugs? Yes☐ No☐

8. Have you ever used tobacco? Yes☐ No☐

If yes:

a. Number of years as a nicotine user: _____.
b. Amount per day _____.
c. Year quit _____.
d. Check the type of nicotine you used: ☐ cigarette ☐ smokeless ☐ cigar ☐ pipe ☐ patch/gum

9. Are you exposed to second hand smoke regularly? Yes_☐_____ No_☐_____

10. Family History:

	Stroke	Heart Disease	High Blood Pressure	Diabetes	Thyroid Disease	Cancer	Cause: Age of Death
Mother							
Father							
Sibling							
Paternal Grandfather							
Paternal Grandmother							
Maternal Grandfather							
Maternal Grandmother							

11. 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					

12. Are you currently, or have you ever been, married? Yes_☐_____ No_☐_____

If so:

a. When were you married? _____
b. Spouse's occupation: _____
c. When were you separated: _____ Never _____
d. When were you divorced? _____ Never _____
e. When were you remarried? _____ Never _____
f. Spouse's occupation _____

Comments: _____

FOR WOMEN ONLY

1. 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 toxemia (high blood pressure)? Yes☐ No☐

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

   If so, please comment: _____
   _____

2. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram_____
   Pap Smear: _____ Normal _____ Abnormal
   Mammogram: _____ Normal _____ Abnormal

   Date of last period _____

3. Have you ever used birth control pills? Yes☐ No☐ If yes, when _____

4. Are you taking the pill now? Yes☐ No☐

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

6. Do you currently use contraception? Yes☐ No☐
   If yes, what type of contraception do you use? _____

7. Are you in menopause? No ☐ Yes ☐ If yes, age at last period_____
   Do you take: Estrogen?☐ Ogen?☐ Estrace?☐ Premarin?☐ Other (specify)_____
   Progesterone?☐ Provera?☐ Other (specify) _____

8. How long have you been on hormone replacement therapy (if applicable)? _____

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

Medical Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale:

0¶ *Never* or *almost never* have the symptom
1¶ *Occasionally* have it, effect is *not severe*
2¶ *Occasionally* have it, effect is *severe*
3¶ *Frequently* have it, effect is *not severe*
4¶ *Frequently* have it, effect is *severe*

Head

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **Total _____**

Eyes

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include enar or far-sightedness) **Total _____**

Ears

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **Total _____**

Nose

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **Total _____**

Mouth/Throat

_____ Chronic coughing
_____Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores **Total _____**

Skin

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **Total _____**

Heart

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain **Total _____**

Lungs

_____ Chest congestions
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total _____**

Digestive Tract

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **Total _____**

Joints/Muscle

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness **Total _____**

Weight

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight **Total _____**

Energy/Activity

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **Total _____**

Mind

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities **Total _____**

Emotions

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressivness
_____ Depression **Total _____**

Other

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **Total _____**

GRAND TOTAL ***TOTAL*** **_____**

WMA Daily Diet Questionnaire

Name: _____ Date: _____

Please provide examples of your typical meals and snacks throughout the day.

Breakfast (include drinks)

_____
_____
_____

Snacks/Drinks

_____

Lunch (include drinks)

_____
_____
_____

Snacks/Drinks

_____

Dinner (include drinks)

_____
_____
_____

Snacks/Drinks

_____

Alcohol: List average number of drinks consumed per week, if any:

_____

How many glasses of water do you usually drink per day? Source?

_____

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