

Welcome to Functional Medicine of Houston! This is your new patient information packet. Please take the time to read, fill out, and sign the appropriate sections. Please be punctual for your scheduled appointment time as this allows us to better take care of your needs. If you wish to cancel or reschedule your appointment please contact our office **24 hours or more in advance**. There is a **$200 administrative fee for missed appointments or for appointments not cancelled 24 hours in advance.** It is our goal to provide each of our patients the best care possible. If you feel you have been treated otherwise please ask to speak with Dr. Stowe. Thank you for your trust.

**Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI:\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_\_\_**

**Height:\_\_\_\_\_\_\_\_\_\_\_\_Weight\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact:** Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you find our clinic? A referal?**

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**List the main problem(s) you are having or the purpose for your consultation:**

□ Low back pain □ Neck pain □ Fatigue □ Osteoporosis

□ Mid back pain □ Headaches □ Diabetes □ Arthritis

□ Shoulder pain □ Elbow pain □ Thyroid disorder □ Cancer

□ Hand/wrist pain □ Hip pain □ High blood pressure □ Acid reflux

□ Knee pain □ Foot/ankle pain High Cholesterol □ Other

**Please list your health concerns in order of your priority.**

1 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long ago did your symptoms begin?

1 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What types of treatments have you received for your condition?

1 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any of these treatments been helpful and if so which ones?

1 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your symptoms worse (i.e. certain movements, weather changes, etc)?

1 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5 - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you are having any pain symptoms, please describe:**

Achy □ Sharp □ Dull □ Burning □ Tight □ Numb □ Stiff □ Throbbing □ Shooting □ Stinging □ Stabbing □ Other □

**How often do your symptoms occur?**

Constant □ Frequent □ Intermittent □

**Is it worse in the:** oA.M.

o P.M.

o After activity

o With movement

o Other

Please describe pain issues you are experiencing:

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

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**Please use the diagram below to demonstrate the location of your pain:**

**Rate the severity of your pain:** No pain 0-1-2-3-4-5-6-7-8-9-10 Severe Pain

**Rate your overall health:** Poor 0-1-2-3-4-5-6-7-8-9-10 Excellent

**Rate your energy levels:** Poor 0-1-2-3-4-5-6-7-8-9-10 Excellent

**Please use the diagram below to demonstrate the location of your pain:**



**Symptoms Questionnaire:** The following questions have been developed to help evaluate your health needs. This process is only as accurate as the information that you provide. If you feel that the topics below do not allow you to verbally express your problem(s), please elaborate **during** our personal consultation. I would like to remind you that all of this information is strictly confidential unless you state otherwise**.** If your answer to the question is No, simply leave the question blank. **If you would like to elaborate, please do so during your consultation. DO NOT WRITE ON THE SPACE/LINE BELOW THE QUESTION**

1. Were you breastfed as a baby? If yes how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Yes**

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

2. Were you delivered via cesarean section? **Yes**

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3. Have you been through any stressful situations recently? **Yes**

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4. Do you consider yourself to be a person who is easily stressed out? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**5**.** Do you need glasses to see things at a distance? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

8. Are your eyes often red or inflamed? **Yes**

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9. Do your eyes or face often appear puffy? **Yes**

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10. Do your eyelids constantly twitch? **Yes**

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11. Are your eyes often dry and itchy? **Yes**

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12. Do you often have dark circles under your eyes? **Yes**

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13. Is your mouth, eyes, or throat chronically itchy or dry? **Yes**

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14. Do you frequently have a sour or metallic taste in your mouth? **Yes**

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15. Do your lips crack and bleed on a regular basis? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

16. Do fever blisters or canker sores often bother you? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

17. Are you troubled by bleeding gums? **Yes**

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18. Have you lost any of your adult teeth? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

19. Do you have a history of dental caries (cavities)? **Yes**

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20. Do you have any metal fillings? **Yes**

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21. Is your tongue usually badly coated? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

22. Do you have chronic halitosis (bad breath)? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

23. Have you ever had fluids leaking from your ear? **Yes**

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24. Do you have constant ringing or noises in your ear? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

25. Do you get dizzy on a regular basis? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

26. Do you have to clear your throat constantly? **Yes**

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27. Are you often troubled with spells of sneezing or allergies? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

28. Is your nose continually stuffed up? **Yes**

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29. Are you sensitive to fumes, smoke, perfumes, or other chemical odors? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

30. Do you often find it difficult to breathe out of your nose? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

31. Do you suffer from a constantly running nose? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

32. Do you ever have spontaneous nosebleeds? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

33. Have you noticed any changes in your ability to taste or smell recently? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

34. Do you suffer from asthma or any other chronic lung disease? **Yes**

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35. Are you troubled by constant coughing? **Yes**

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36. Do you get sick more than twice per year? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

37. Have you taken antibiotics recently? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

38. Have you had to take antibiotics more than once for a chronic ailment? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

39. Do you suffer from frequent or severe headaches? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

40. Do you often have sinus congestion? **Yes**

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41. Is your appetite always poor? **Yes**

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42. Do you usually eat sweets or other foods between meals? **Yes**

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43. Do you always gulp your food hurriedly? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

44. Do you often suffer from an upset stomach? **Yes**

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45. Do you usually feel bloated after eating? **Yes**

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46. Do you usually belch a lot after eating? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

47. Are you often sick to your stomach? **Yes**

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48. Do you ever suffer from indigestion? **Yes**

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49. Do you often take medication for heartburn? **Yes**

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50. Have you ever been diagnosed with stomach ulcers? **Yes**

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51. Do you suffer from frequent loose bowel movements? **Yes**

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52. Do you experience gut pain shortly after bowel movements? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

53. Do you have at least one bowel movement per day? **Yes**

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54. Do you ever experience a burning or itching sensation in the anus? **Yes**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

55. Have you ever had severe bloody diarrhea? **Yes**

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56. Is the color of your stool often tan? **Yes**

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57. Is the color of your stool ever dark black? **Yes**

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58. Were you ever troubled with intestinal worms or parasites? **Yes**

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59. Do you constantly suffer from constipation? **Yes**

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60. Have you traveled out of the country recently? **Yes**

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61. Have you ever had jaundice (yellow eyes and skin)? **Yes**

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62. Have you ever had serious liver or gall bladder trouble? **Yes**

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63. Do you find it difficult to get to sleep at night? **Yes**

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64. Do you have difficulty remembering dreams from the night before **Yes**

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65. Are you exhausted upon waking in the morning? **Yes**

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66. Do you need coffee to wake up and have energy in the morning? **Yes**

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67. Are you often exhausted or fatigued? **Yes**

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68. Do you sleep less than 8 hours a day? **Yes**

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69. Does every little effort wear you out? **Yes**

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71. Are you frequently confined to bed by illness? **Yes**

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72. Do you feel like you are always in poor health? **Yes**

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73. Are you considered a sickly person? **Yes**

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74. Did you ever have Scarlet fever, Rheumatic fever, Malaria? **Yes**

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75. Were you ever treated for severe anemia? **Yes**

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76. Were you ever treated for venereal disease? **Yes**

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77. Do you have diabetes? **Yes**

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78. Did a doctor ever say you had a goiter in your neck? **Yes**

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79. Did a doctor ever treat you for a tumor or cancer? **Yes**

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80. Do you suffer from any chronic disease? **Yes**

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81. Did you ever have a serious injury? **Yes**

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82. Are your joints often painfully swollen? **Yes**

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83. Do you have constant muscle aches and pains? **Yes**

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84. Do your muscles and joints constantly feel stiff? **Yes**

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85. Have you ever been told that you had arthritis? **Yes**

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86. Do pains in the back make it hard for you to keep up with your work? **Yes**

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87. Do muscle cramps or spasms frequently bother you? **Yes**

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88. Do you have numbness or tingling in any part of your body? **Yes**

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89. Do your feet ever feel like they burn? **Yes**

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90. Have you ever had a seizure or convulsion? **Yes**

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91. Has a doctor ever said your blood pressure was too high? **Yes**

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92. Has a doctor ever said your blood pressure was too low? **Yes**

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93. Do you have pains in the heart or chest? **Yes**

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94. Are you often bothered by thumping of the heart? **Yes**

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95. Does your heart often race like mad? **Yes**

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96. Do you often have difficulty with breathing? **Yes**

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97. Do you run out of breath easily? **Yes**

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98. Do you sometimes get out of breath just sitting still? **Yes**

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99. Are your ankles often badly swollen? **Yes**

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100. Do cold hands or feet trouble you, even in hot weather? **Yes**

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101. Do you suffer from frequent cramps in your legs? **Yes**

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102. Has a doctor ever said you had heart trouble? **Yes**

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103. Does heart trouble run in your family? **Yes**

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104. Has your cholesterol ever been high? **Yes**

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105. Do you get up every night to urinate? **Yes**

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106. During the day, do you usually have to urinate frequently? **Yes**

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107. Do you often have severe burning when you urinate? **Yes**

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108. Do you sometimes lose control of your bladder? **Yes**

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109. Has a doctor ever said you had kidney or bladder disease **Yes**

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110. Is your memory poor? **Yes**

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111. Do you have difficulty remembering daily tasks or recent events? **Yes**

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112. Do your thoughts seem foggy or cloudy? **Yes**

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113. Do you find it difficult to focus or concentrate on daily activities? **Yes**

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114. Have you ever been under the care of a psychiatrist? **Yes**

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115. Does worrying continually get you down? **Yes**

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116. Do you feel alone and sad at a party? **Yes**

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117. Do you usually feel unhappy or depressed? **Yes**

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118. Do you often cry? **Yes**

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119. Have you ever had a nervous breakdown? **Yes**

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120. Do you always do things on sudden impulse? **Yes**

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121. Are you easily upset or irritated? **Yes**

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122. Do little annoyance get on your nerves/ get you angry? **Yes**

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123. Do people often annoy and irritate you? **Yes**

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124. Do you often shake or tremble? **Yes**

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125. Are you constantly keyed up or jittery? **Yes**

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126. Do frightening thoughts keep coming back in your mind? **Yes**

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127. Do you often become frightened for no apparent reason? **Yes**

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128. Do you often break out in a cold sweat? **Yes**

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129. Does life look entirely hopeless? **Yes**

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130. Do you often wish you were dead and away from it all? **Yes**

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131. Do you bruise easily? **Yes**

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132. Does it take longer than 10 days for a cut or bruise to heal? **Yes**

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133. Is acne constantly a problem? **Yes**

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134. Is your skin constantly broken out with bumps? **Yes**

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135. Do you have to wear lotion to keep your skin from drying out? **Yes**

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136. Do you break out in rashes on a regular basis? **Yes**

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137. Is your hair dry and brittle? **Yes**

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138. Are your finger nails weak or ridged? **Yes**

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139. Do you have food cravings? **Yes**

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140. Are you hungry shortly after a meal? **Yes**

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141. Do you eat out at restaurants frequently? **Yes**

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142. Do you consume fast food often? **Yes**

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143. Do you drink soda on a daily basis? **Yes**

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144. Do you have a history of sexual promiscuity with multiple partners? **Yes**

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145. Have you ever been diagnosed with a sexually transmitted disease? **Yes**

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146. Have you ever been a substance abuser? **Yes**

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147. Have you ever abused alcohol? **Yes**

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148. Do you drink alcohol on a daily basis? **Yes**

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149. Do certain foods make you feel ill? (corn, wheat, dairy) **Yes**

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150. Do you smoke or use any tobacco products? **Yes**

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151. Are you constantly exposed to second hand smoke? **Yes**

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152. Do you consider yourself to be over weight? **Yes**

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153. Do you consume less than 5 servings of fruits and vegetables per day? **Yes**

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154. Do you exercise 5 times per week or more? **Yes**

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155. Does fatigue keep you from exercising? **Yes**

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156. Is your water intake less than 64 ounces (8 cups) per day? **Yes**

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157. Do you get less than 2 hours/week direct sun without using sunscreen? **Yes**

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158. Do you consume foods which contain artificial sweeteners? **Yes**

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159. Have you ever been exposed to mold?  **Yes**

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160. Do you see undigested food in stool? Yes

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161. Is your stool foul smelling, have mucus or seem greasy? Yes

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162. Do you frequently lose your appetite? Yes

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163. Do you believe you have excessively foul-smelling sweat? Yes

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164. Does eating relieve fatigue? Yes

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165. Are you fatigued after you have a meal? Yes

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166. Do you crave salt? Yes

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167. Do you have morning headaches that wear off as day progresses? Yes

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If you experience other symptoms not asked about, please elaborate below:

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**Past Medical History: please indicate below any health problems you have experienced in the past.**

**Major Illnesses (Please list dates when conditions were diagnosed):**

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**Accidents or Major Trauma (Please list dates. For scars please give locations):**

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**Surgeries/Hospitalizations (Please list dates):**

[ ] Colostomy [ ] Esophageal [ ] Cholecystectomy

[ ] Gastric [ ] Ileostomy [ ] Nephrectomy

[ ] Hemorrhoidectomy [ ] Tonsillectomy [ ] Appendectomy

[ ] Bowel (intestinal) [ ] Vasectomy [ ] Hysterectomy

[ ] Other

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**Dental Procedures (Root canals, total number of cavities, etc):**

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**Allergies and/or Sensitivities (Drugs, chemicals, foods, environmental):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Occupational Exposures (i.e. mercury, asbestos, etc):**

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**Lifestyle - Check those that apply to you:**

[ ] Alcohol ( daily weekly monthly)

[ ] Exercise ( none daily weekly monthly )

[ ] Housebound

[ ] Smoker ( \_\_\_\_\_\_\_ packs/day)

[ ] Soft drink consumption ( \_\_\_\_/day)

[ ] Coffee consumption ( \_\_\_\_ cups/day)

[ ] Sedentary Job

[ ] Fast food consumption (daily weekly monthly)

[ ] Sexually active

[ ] Married (yes, no, divorced)

**Women Only:** Last Pap\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last menstrual period\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital History: Years married\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of children-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of Pregnancies\_\_\_\_\_\_\_\_\_\_

Deliveries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use of Contraceptives?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently menstruating? \_\_\_\_\_\_\_\_\_\_\_\_\_

Abnormal Pap (HPV, CIN, etc.)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***If yes check any of the following symptoms you experience around your periods****:*

[ ] Heavy bleeding [ ] Painful cramping [ ] Intense mood swings [ ] Bloating

[ ] Food Cravings (sweets, etc.) [ ] Headaches [ ] Irregularly timed cycles

[ ] Extreme fatigue [ ] Anxiety [ ] Depression [ ] Breast tenderness

***If peri/post-menopausal check any symptoms that you are currently experiencing:***

[ ] Hot/cold flashes [ ] Vaginal dryness [ ] Hair loss [ ] Dry skin

**Men Only:** Date of last prostate exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abnormal Prostate findings?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital History: Years married\_\_\_\_\_\_\_\_\_

# of children\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate your job stress (0: low to 10:very high)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutritional (diseases, diet, food habit, etc):**

[ ] Anorexia [ ] Bulimia [ ] Carbohydrate Loading

[ ] Fasting (chronic) [ ] Fiber Intake (high)

[ ] Lactose Intolerance [ ] Salt Intake (high)

[ ] Malnutrition [ ] Protein Intake (high)

[ ] Saturated Fat Intake (high)

[ ] Vegetarian Diet [ ] Vegan Diet [ ] Weight Loss (involuntary)

[ ] Atkins Diet [ ] Hollywood Diet [ ] South Beach Diet

[ ] Other diet : Please list and describe below.

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**Nutritional Supplements** – Please use the chart below to list all vitamins, minerals, amino acids, or other supplemental products (meal replacement drinks bars, etc.) you are currently taking.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Supplements | Brand | Form | Dose/Frequency | For How Long |
| For Example: Vitamin E | Nature's Way | Soft gel cap | 1 / day | 2 years |
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**Medications –** Please list all medications (prescription and over the counter) you are currently taking

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Physician | Form | Dose/Frequency | For How Long |
| For Example: Prozac | Dr. Smith | Capsule | 1 / day | 2 years |
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**Diet Recall: Please give an example of the foods and beverages you TYPICALLY consume? How many times a day do you eat?\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BREAKFAST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LUNCH:**

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**DINNER:**

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**SNACKS:**

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Please provide any other information about your diet that you feel would provide additional information that the doctor might need:

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

**Family Medical History: Please give age, lists of any illness, or if deceased.**

**If deceased, list cause of death and age at death.**

**Examples:**

**Children:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Arthritis-Type**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Genetic Disease - Type**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Celiac Disease**

**Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alzheimer’s**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcoholism**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asthma**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bleeding Tendency**

**Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer-Type**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Crohn’s Disease**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes-Age at Onset**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drug Abuse**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Epilepsy**

**Brothers and Sisters: Gall Bladder**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Glaucoma**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Disease-Type**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hearing Loss**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hypoglycemia**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kidney Disease**

**Liver Disease-Type**

**Mother’s Parents: Osteoporosis**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lupus**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Illness- Type**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Multiple Sclerosis**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rheumatoid Arthritis**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid Disease**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tuberculosis**

**Skin Disease-Type**

**Father’s Parents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Conditions**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\* Very Important Information \*\***

**Please Read Carefully and Sign After Reading**

**Payment Requirements:** Payment for all services is expected at the time of appointment. Visa, MasterCard, Discover Card, checks and cash are accepted.

**Appointments:** Please kindly give at least 24 hour notice if you must change or cancel your appointment. **We charge a $200 fee for missed appointments or if less than 24 hour notice is given (at office discretion)**. Please remember that the charge for your first office visit and physical exam does not include lab or supplement costs.

“I understand and agree that my health insurance is an agreement between my insurance company carrier and myself, but that all services furnished to me by Functional Medicine of Houston are charged directly to me. I further understand that Functional Medicine of Houston will, at my request, supply me with a “super bill” that I can submit to my insurance company for possible re-imbursement. Functional Medicine of Houston will, in any reasonable manner, assist me in my efforts to obtain collection from my insurance company; however, I understand that there is no guarantee that I will receive any re-imbursement.

**I have read and understand the above statements.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please Print Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness signature**

**If you would like us to be able to communicate information (lab results, x-rays, etc) about your condition to a family member or designated person in your absence, please list them below.**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give Functional Medicine of Houston my permission to share my medical information with the following people in my absence (please list names below):**

**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**