



Elisa Song, MD | Donna Ruiz, MD | Suruchi Chandra, MD | Christina Peretz, MD | Kandice Stellmon, NC

Adult New Patient Health Questionnaire

Thank you for taking the time to fill out this new patient health questionnaire. This questionnaire is an important part of your initial consultation. Accurate completion of this form will ensure more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will assist your doctor in formulating the most appropriate treatment plan.

Personal Information			
Patient's Name: _____	Date of Birth: _____	Male	Female
Requesting appointment with:			
<input type="checkbox"/> Dr. Christina Peretz <input type="checkbox"/> Dr. Suruchi Chandra			
Form Completed by (include relation to patient):			
Name/Address of Primary Care Physician:			
Name/Address of Additional Therapists/Specialists Working With You (if any):			
Name/Address of Additional Therapists/Specialists Working With You (if any):			
Name/Address of Additional Therapists/Specialists Working With You (if any):			

Please check appropriate box(es):

- | | | | |
|---|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other _____ |



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Diagnosis

Please describe your main medical diagnoses or problem(s) that you would like addressed today:

Dates of diagnosis and diagnosing practitioner (please include address and telephone number):

What factors or events, if any, do you believe may have triggered your problem/illness?

What are your goals of treatment?

Please describe yourself, in as much detail as possible (personality, likes and dislikes, temperament, etc.). Tell me your story (you may use the additional sheet at the end of this document if necessary)...

Current Symptoms or Health Concerns

- | | | |
|---|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Autoimmune Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Energy Problems | <input type="checkbox"/> Environmental Issues |
| <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chronic Lyme or other Tick-Borne Illness |
| <input type="checkbox"/> Medications/Therapies | <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Sleep Issues | <input type="checkbox"/> Low libido/sex drive |
| <input type="checkbox"/> Reflux/heartburn | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Menstrual disorders/PMS | <input type="checkbox"/> Infertility | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Other Neurologic Issues (please describe): | | |
| <input type="checkbox"/> Other (please describe): | | |



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Current Therapies

Please describe your current therapies:

- | | | | |
|---|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Craniosacral | <input type="checkbox"/> Energy therapy |
| <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Naturopathy | <input type="checkbox"/> Osteopathy | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Other (please describe): | | | |

Please list all therapies tried and stopped (use additional sheet at the end of this document if necessary):

<u>Therapy Tried</u>	<u>Reason Stopped</u>

Past Medical History

<u>Illnesses</u>	<u>When</u>	<u>Comments</u>
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
Gout		
Heart attack/Angina		
Heart failure		
Hepatitis		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel		



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Past Medical History		
<u>Illnesses</u>	<u>When</u>	<u>Comments</u>
Kidney stones		
Mononucleosis		
Pneumonia		
Rheumatic fever		
Sinusitis		
Sleep apnea		
Stroke		
Thyroid disease		
Other (describe)		
<u>Injuries</u>	<u>When</u>	<u>Comments</u>
Back injury		
Broken (describe)		
Head injury		
Neck injury		
Other (describe)		
<u>Diagnostic Studies</u>	<u>When</u>	<u>Comments</u>
Barium Enema		
Bone Scan		
CAT Scan of Abdomen		
CAT Scan of Brain		
CAT Scan of Spine		
Chest X-ray		
Colonoscopy		
EKG		
Liver scan		
Neck X-ray		
NMR/MRI		
Sigmoidoscopy		
Upper GI Series		
Other (describe)		



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Past Medical History		
<u>Operations</u>	<u>When</u>	<u>Comments</u>
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Other (describe)		
Other (describe)		
<u>Hospitalizations - Where</u>	<u>When</u>	<u>For What Reason</u>

Childhood History				
Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. Was your development normal?				



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Medication/Supplement History

Please list all current medications, vitamins, nutritional supplements, herbs, homeopathic remedies, etc. (use additional sheet at the end of this document if necessary):

<u>Supplement/Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Date Started</u>

How often have you have taken antibiotics?

< 5 times > 5 times

Infancy/ Childhood		
Teen		
Adulthood		

How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

< 5 times > 5 times

Infancy/ Childhood		
Teen		
Adulthood		

Allergies/Sensitivities

Please list any medications or supplements that you have had a reaction to. Describe the reaction:

Please list any other sensitivities that you have, or that you suspect you may have:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Perfumes/cosmetics | <input type="checkbox"/> Cleaning products | <input type="checkbox"/> Soaps | <input type="checkbox"/> Detergents |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Mold | <input type="checkbox"/> Pollens/Grasses | <input type="checkbox"/> Animals (dander) |
| <input type="checkbox"/> Gasoline | <input type="checkbox"/> Chemicals | <input type="checkbox"/> Other (please describe): | |
| <input type="checkbox"/> Foods, which ones? | | | |



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Medication/Supplement History	
Please list all medications/supplements stopped secondary to not working or negative response. If there was a negative response, please describe. (use additional sheet at the end of this document if necessary):	
<u>Supplement/Medication</u>	<u>Reason Stopped</u>

Environmental History	
Water: <input type="checkbox"/> City <input type="checkbox"/> Well	Purification system? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
Type of Heat: <input type="checkbox"/> Electric <input type="checkbox"/> Gas <input type="checkbox"/> Oil <input type="checkbox"/> Other	If other, please describe:
Live near: <input type="checkbox"/> Power lines <input type="checkbox"/> Woods <input type="checkbox"/> Industrial Areas <input type="checkbox"/> Water (what kind?)	
Bedding: <input type="checkbox"/> Down <input type="checkbox"/> Synthetic	Mattress/pillow cover? <input type="checkbox"/> Yes <input type="checkbox"/> No
Flooring: <input type="checkbox"/> Carpet <input type="checkbox"/> Area rug <input type="checkbox"/> Wood <input type="checkbox"/> Other	If other, please describe:
Does your home have a lot of: <input type="checkbox"/> Dust <input type="checkbox"/> Mold	
Travel history:	
Please list any other exposures you may have had in the past and present:	



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Sleep History

Please describe the pattern and quality of your sleep? (i.e., do you sleep soundly, or toss and turn, have nightmares? Do you wake up refreshed?)

What time do you typically fall asleep at night?

What time do you typically wake up?

How many hours of sleep do you get every day?

Do you fall asleep easily? Yes No If no, please explain:

Do you stay asleep through the night? Yes No If no, please explain:

Exposure History

Have you ever used alcohol?

Yes No

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

Have you ever had a problem with alcohol?

Yes No

If yes, please indicate time period (month/year):

from _____ to _____

Have you ever used recreational drugs?

Yes No

Have you ever used tobacco?

Yes No

If yes, what type of nicotine have you used?

- Cigarette Smokeless Patch/Gum
- Cigar Pipe

If yes, number of years as a nicotine user: _____ Amount per day _____. Year quit _____.

Are you exposed to second hand smoke regularly? Yes No

Do you have mercury amalgam fillings? Yes No

Do you have any artificial joints or implants? Yes No

Do you feel worse at certain times of the year? Yes No

If yes, when? Spring Summer Fall Winter

Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes No

If yes, which one(s)? Lead Cadmium Mercury
 Arsenic Aluminum Others: _____

Do odors affect you? Yes No



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Digestive History

How often do you have a bowel movement?

What is your stool like (check all that apply)?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Well-formed | <input type="checkbox"/> Mucousy | <input type="checkbox"/> Loose, falls apart | <input type="checkbox"/> Watery |
| <input type="checkbox"/> Small, hard pieces | <input type="checkbox"/> Greasy, floats | <input type="checkbox"/> Bloody | <input type="checkbox"/> Thin and long, ribbons |
| <input type="checkbox"/> Foul-smelling | <input type="checkbox"/> Painful | <input type="checkbox"/> Lots of undigested food particles | |
| <input type="checkbox"/> Medium/dark brown | <input type="checkbox"/> Yellow/light brown | <input type="checkbox"/> Greenish | <input type="checkbox"/> Very dark or black |
| <input type="checkbox"/> Other (please describe): | | | |

Do you have heartburn or reflux? Yes No (If yes, please list any treatments):

Do you have frequent gas or belly bloating? Yes No (If yes, please describe):

Do you have any abdominal pain? Yes No (If yes, please describe how often and nature of pain):

Diet History

Please describe your current diet:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> No restrictions | <input type="checkbox"/> Gluten Free | <input type="checkbox"/> Casein Free | <input type="checkbox"/> Yeast Free |
| <input type="checkbox"/> Salicylate Free | <input type="checkbox"/> Low Phenolics | <input type="checkbox"/> Organic | <input type="checkbox"/> High Protein/Low Carb |
| <input type="checkbox"/> IgG Reactive Foods Avoidance | | <input type="checkbox"/> Specific Carbohydrate Diet | |
| <input type="checkbox"/> Diabetic Diet | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Vegan | <input type="checkbox"/> Bloodtype diet |
| <input type="checkbox"/> Ketogenic Diet | <input type="checkbox"/> Low Phenolics | <input type="checkbox"/> Organic | <input type="checkbox"/> High Protein/Low Carb |
| <input type="checkbox"/> Other (please describe): | | | |

Do you have any concerns about your current diet? Yes No
If yes, what concerns?



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Diet History

Please describe your typical breakfast:

Please describe your typical lunch:

Please describe your typical dinner:

Please describe your typical snacks:

What do you drink throughout the day?

Do you eat refined sugar? Yes No (If yes, what kind and how often):

Do you eat fast food? Yes No (If yes, what kind and how often):

Do you eat food with artificial colors/flavorings or preservations? Yes No (If yes, how often):

Do you eat artificial sweeteners? Yes No (If yes, what kind and how often):

Do you drink soda? Yes No (If yes, what kind and how often):

How many cups of caffeinated coffee or tea do you drink daily?

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc? Yes No
If yes, are these symptoms associated with any particular food or supplement(s)? Yes No
Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more) such as fatigue, muscle aches, sinus congestion, etc.? Yes No
Please describe:



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Diet History

Do you feel much worse when you eat a lot of :

- | | |
|--|---|
| <input type="checkbox"/> High fat foods
<input type="checkbox"/> High protein foods
<input type="checkbox"/> High carbohydrate foods
(breads, pastas, potatoes) | <input type="checkbox"/> Refined sugar (junk food)
<input type="checkbox"/> Fried foods
<input type="checkbox"/> 1 or 2 alcoholic drinks
<input type="checkbox"/> Other: _____ |
|--|---|

Do you feel much better when you eat a lot of :

- | | |
|--|---|
| <input type="checkbox"/> High fat foods
<input type="checkbox"/> High protein foods
<input type="checkbox"/> High carbohydrate foods
(breads, pastas, potatoes) | <input type="checkbox"/> Refined sugar (junk food)
<input type="checkbox"/> Fried foods
<input type="checkbox"/> 1 or 2 alcoholic drinks
<input type="checkbox"/> Other: _____ |
|--|---|

Does skipping a meal greatly affect your symptoms? Yes No

Have you ever had a food that you craved or really "binged" on over a period of time? Yes No
 Food craving may be an indicator that you may be allergic to that food.
 If yes, what food(s)?

Do you have an aversion to certain foods? Yes No
 If yes, what foods?

Please list all diets tried and stopped (use additional sheet at the end of this document if necessary):

<u>Diet Tried</u>	<u>Reason Stopped</u>



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Social History

How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Please list any pets in the house:

Please describe family relationships:

Please describe any recent stressful events (life changes, losses, births, deaths, divorce, remarriage, moves, illness, financial problems, arguments with family/friend, etc.):

Hobbies and leisure activities:

Do you exercise regularly? Yes No

If so, how many times a week?

- 1x
- 2x
- 3x
- 4x or more

When you exercise, how long is each session?

- ≤15 min
- 16-30 min
- 31-45 min
- > 45 min

What type of exercise is it?

- Jogging/walking
- Basketball
- Home aerobics
- Tennis
- Water sports
- Other: _____

What is the attitude of those close to you about your health or illness?

- Supportive
- Non-supportive



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For Women Only

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 high blood pressure and/or pre-eclampsia? Yes No

Have you had other problems with pregnancy? Yes No

If so, please comment: _____

Age at first period: _____ Date of last Pap Smear: _____ Date of last Mammogram: _____

Pap Smear: Normal Abnormal

Mammogram: Normal Abnormal

Have you ever used birth control pills? Yes No If yes, when: _____

Are you taking the pill now? Yes No

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

Do you currently use contraception? Yes No

If yes, what type of contraception do you use? _____

Are you in menopause? Yes No If yes, age at last period: _____

Do you take: Estrogen Ogen Estrace Premarin Other (specify): _____

Progesterone Provera Other (specify): _____

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

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?

Yes No Not applicable

Any other concerns:

- Breast cysts/lumps
- Poor sex drive/libido
- Vaginal discharge
- PMS
- No periods
- Others:

- Breast tenderness
- Endometriosis
- Vaginal odor
- Menstrual cramps
- Scanty periods

- Ovarian cysts
- Fibroids
- Vaginal itch
- Heavy periods
- Spotting between

- Infertility
- Vaginal pain
- Irregular periods



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Mental Health History

Do you have any of the following symptoms currently or in the past. Indicate c for current, p for past

- _____ Thoughts of harming yourself
- _____ Thoughts of harming others
- _____ Self-injurious behaviors (i.e. cutting, burning, etc.)
- _____ Alcohol abuse or dependence
- _____ Recreational drug use
- _____ Psychosis
- _____ Periods of mania

If yes to any of the above, please comment further below. Include dates that you experienced symptoms as well as treatments:

Have you ever been hospitalized for psychiatric reasons? Yes No

Total number of inpatient hospitalizations _____

If so, please list the dates, location, and reasons for all hospitalizations:

Have you ever been treated in a day or partial program? Yes No

If so, please list the dates, locations, and reasons for all treatment programs:



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Additional Space

Please send copies of any evaluations, consultations, laboratory tests, vaccinations, and any other information you feel is important for us to review.

Please use this space to describe anything else you would like us to know about you. List any other history, pertinent thoughts, or question that you would like to address: