



Health History & Neurotoxic Questionnaire

Date: Insurance:

Name:

Address:

City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

E-mail Address:

Age: Date of Birth: Gender: Male Female

Status:

- Married
- Separated
- Divorced
- Widowed
- Single
- Partnership

Live with:

- Spouse
- Partner
- Parents
- Children
- Friends
- Alone

Education:

Occupation: Hours per week: Retired

Employer	Work Address

In case of emergency, who should we contact?

Name	Relationship	Address	Phone

How did you hear about our Wellness and Nutrition Program?

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			

3.			
4.			
5.			
6.			
7.			

MEDICATIONS & SUPPLEMENTS

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Supplements: List all vitamins, minerals and other nutritional supplements that you are currently taking.

Medication Name	Dosage

Supplement Name/Brand	Dosage

Have your medications or supplements ever caused you unusual side effects or problems?

Yes ___ No ___ If yes, please describe: _____

PREGNANCY HISTORY (Check box if yes and provide number of)

- Pregnancies _____
- Miscarriage _____
- Post partum depression
- Baby over 8 pounds
- Caesarean _____
- Abortion _____
- Toxemia
- Breast feeding For how long? _____
- Vaginal deliveries _____
- Living Children _____
- Gestational diabetes

FOR THE CYCLIC-AGE WOMAN

Age at 1st period: _____ Menses Frequency: _____ Length of period: _____ Pain: Yes ___ No ___
 Clotting: Yes ___ No ___ Has your period skipped? _____ For how long? _____
 Last Menstrual Period: _____ How many days is your current cycle?
 Do you currently use contraception? Yes ___ No ___ If yes, what type do you use?
 Condom Diaphragm IUD Partner vasectomy
 Have you ever used hormonal contraception? Yes ___ No ___ If yes, when _____
 Use of hormonal contraception: Birth control pills Patch/Injection Nuva Ring
 Are you using the pill now? Yes ___ No ___ Did taking the pill agree with you? Yes ___ No ___

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes No

Date of last Mammogram _____ Breast Biopsy/Date _____

Last PAP Test: _____ Normal _____ Abnormal _____

Other information for us to know: _____

FOR THE WOMAN IN MENOPAUSE

Age at onset of menopause: _____ Year of onset of menopause: _____

When you were cycling, would you consider your cycle regular? Yes ____ No ____

If no, why? _____

When you were cycling, what was your typical menstrual flow? Light ____ Medium ____ Heavy ____

Have you had a hysterectomy? Complete (ovaries and uterus) _____ Partial (uterus only) _____

Date of hysterectomy _____ Reason for hysterectomy: _____

Date of last Mammogram _____ Breast Biopsy/Date _____

Date of last Bone Density _____ Results: High Low Within normal range

Are you in menopause? Yes ____ No ____ Age at Menopause _____

Do you take: Estrogen Ogen Estrace Premarin Progesterone
 Provera Other _____

How long have you been on hormone replacement? _____

Other information for us to know: _____

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.)

Is there anything in your medical history that you consider to be relevant?

What is your employment history? Please provide brief summary.

Please list past or present allergies, including allergies to medications.

Please list all past surgeries and the condition each surgery was for.

Please explain your housing history (type of homes, where and when).

Patient History

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

			Mercury			
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you have amalgam fillings in your teeth?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you ever had dental X-rays?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Did your mother have dental X-rays while pregnant with you?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you ever worked in a dental office? If so, how long? _____		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you had any dental procedures, root canals, dry sockets or infected tooth extractions?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you have any dental crowns or other metal in your mouth?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Did you wear contact lenses during the 1980's or early 1990's?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Did you take oral contraceptives during the 1980's or early 1990's?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you noticed any adverse reactions to these shots?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you have any tattoos with red ink?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?		

			Lead			
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does your occupation involve painting, metal salvage, old home repair or sandblasting?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Was your home built before 1978?		
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Have you ever worn lead aprons or lead shielding?		

General Toxicity

- Yes No Have you ever lived in a home with lead pipes, freeway or tension wires? If yes, please explain.
- Yes No Have you ever had contact with hazardous materials (i.e. cleaning chemical spills, working in a beauty salon, etc.)?

Mold

- How old is the house you are living in? _____
- Yes No Do you see mold growing in your home, work or school?
 - Yes No Have you ever had water damage in your home, work or school?
 - Yes No Does your home, work or school have a damp or mildew smell?
 - Yes No Does spending time in your home, work or school cause or worsen your symptoms?
 - Yes No Does your basement or crawlspace have water damage or mold?
 - Yes No Does spending time in your home, work or school for at least a few days cause a noticeable decrease in your energy level?

Lyme Disease

- Yes No Have you ever been diagnosed with Lyme Disease?
- Yes No Have you ever been bitten by a tick or a recluse spider?
- Yes No Have you ever seen a tick or a recluse spider on any part of your body?
- Yes No Did the bulls-eye rash ever appear on your body following a tick, spider bite or time spent outdoors?
- Yes No Was your mother ever diagnosed with Lyme Disease?
- Yes No Do you frequently spend time outdoors or are you involved in outdoor activities (specifically in wooded areas)?

Health History

- Yes No Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple sclerosis?
 - Yes No Does anyone in your family have similar symptoms to yours? _____.
- What is your birth order (i.e. first born, second born, etc.)? _____.
- Yes No Do you have any history of autoimmune disease?
 - Yes No Do you or any immediate family members have a history with cancer?
 - Yes No Do you have any history of heart disease, myocardial infarction (heart attack), etc.?
 - Yes No Are you currently having any thoughts of suicide?
 - Yes No Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?
 - Yes No Do you have a history of strokes?
 - Yes No Have you ever been diagnosed with diabetes mellitus?
 - Yes No Have you ever been in an auto accident, fallen or received a major physical injury?
 - Yes No Are you in menopause?

Yes No Do you have any allergies to food or medication?

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

0 = Never had the symptom 2 = Occasionally have it, severe effect 4 = Frequently have it, severe effect
 1 = Occasionally have it, mild effect 3 = Frequently have it, mild effect

Column #1

Anxiety
Mood swings
Enraged behavior or anger for no reason
Excessive shyness, timidity, social phobia (not typical to your personality)
Irritability (not typical to your personality)
Low body temperature (below 97.5°)
Insomnia (can't get to sleep or return to sleep)
Dizziness
Sound in ears (ringing or hearing your heart beat)
Psychological symptoms, even thoughts of suicide
Sensitivity to sound

Column #2

Sensitivity to light
Fatigue after exercising (feeling worse)
Bad night vision or seeing halos around lights
Shortness of breath, with very little effort
Excessive thirst and/or frequent urination
Red eyes or tearing
Blurred vision at times
Morning stiffness
Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
Chronic fatigue or weakness
Non-restful sleep

Indecisiveness
Feeling of being overwhelmed or fearful
Metallic taste in your mouth
Bad breath
Bleeding gums
Sensitive teeth
Canker sores or other sores in the mouth
Floaters, shadows or swimmers when you read or look into the sky
Dyslexia or loss of place while reading, even as a child
Swelling eyelids
Peeling on top layer of skin (hands, feet)
Dry skin
Heart pain (angina) and you are under 45 years old
Depression
Gout (arthritic pain, especially in big toes)
Pain in shoulders or upper back
Twitching eyelids
Anemia (low iron/hemoglobin on blood test)
Wrist/ankle drop or weak extensor muscles
Hair falls out (not normal male pattern baldness)

Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
Trouble processing new information
Word reversal or trouble finding words
Sensitivity to touch
Short-term memory loss
Chronic sinus congestion
Dry non-productive cough
Muscle twitching
Excessive sweating, especially at night
Joint pain-not necessarily true arthritis-can move from joint to joint
Difficulty losing weight regardless of diet or exercise
Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
Frequent illness, prolonged illness or sick days
Numbness or weakness in arms and legs
Headaches
Trouble adding or dividing numbers in your head
Fluctuating constipation and diarrhea
Stomach pain for no apparent reason
Appetite swings
Frequent muscle aches, cramps, unusual sharp sudden pains
Rashes or rosacea
Cold extremities (hands and feet)

Total Columns 1 & 2