

## BRIEF PATIENT HISTORY

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

Name (last, first):	DOB:	Age:
Current Problems/Worst Symptoms:	Medications:	
	Past Illnesses / Surgeries / Age or Year:	
Toxic Home, Hobby, or Work Exposures:		
Musty Basements /Mold Exposure (year/location) -Severity:	Allergies (medications/supplements):	
Social History (cigs, alcohol, drugs, etc.)  Married / Divorced / Children's Ages _____ Is anyone else ill in home? _____	Allergies (environmental e.g. pollens cats):	
	Lyme History: Tick Bite Treatment: Testing Results:	
Significant Family History of Illness: Mother: Father: Siblings: Spouse: Children:	GYN History: Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____ Bad Menstrual Cramps: Yes/No/Severe Last Period: _____ Birth Control Type: _____ Hormones used in the past? Yes/No	

Circle Yes Or No	Yes	Are you very <b>chemically sensitive</b> ? Mild / Moderate / Severe	No
	Yes	Are you <b>EMF sensitive</b> ? Does cell phone heat up in your hand or give you a headache?	No
	Yes	Do fluorescent lights, Wi-Fi, refrigerators, or motors irritate you? (Circle all that apply)	No
	Yes	Do you have to cut out tags from clothing?	No
	Yes	Do you dislike standing for a long time?	No
	Yes	Do you pretzel your legs when sitting?	No
	Yes	Is this worse when sitting at a computer?	No
	Yes	Do you have a fast heartbeat when standing or lying in bed?	No
	Yes	Do you cross your arms or lean on the wall when standing?	No
	Yes	Do you get dizzy upon rising after tying shoes?	No
	Yes	Do you have exercise/heat intolerance? (Circle all that apply)	No
	Yes	Do you crave/or like salt, chips or sugar? (Circle all that apply)	No
	Yes	Are you tired in the morning / 4 p.m.? (Circle all that apply)	No
	Yes	Do you have motion sickness reading in car, on a boat, or while taxiing in a plane	No
	Yes	Do you have trouble walking up a ladder or looking down from heights?	No
	Yes	Do your arms get tired when washing hair / folding laundry?	No
	Yes	Is it difficult to mop the floor / vacuum?	No
	Yes	Are you ill or tired in the mall or home depot?	No
	Yes	Can you smell chemicals inside these stores?	No
	Yes	Do you avoid or smell the detergent aisle in the grocery store?	No
Yes	Is bra too tight and you prefer not to wear one/cannot wear one?	No	
Yes	Do you have arm/skin discomfort if you roll up your tight sleeves?	No	
Yes	Do you urinate more that once at night or many times a day	No	