Environmental Health Center of Martha's Vineyard  **Registration Form and Agreement**

Fill in all spaces that apply. Please print. **Date of completion** _____ **Age** _____ **Date of Birth:** _____

Patient's Name: _____ **E-mail:** _____

Address: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell Phone:** _____

Gender: ____ **Social Security Number:** _____ **Pharmacy Name/Phone:** _____
Marital Status? S/M

Compounding _____

May we leave a message on your answering machine? Y/N On your e-mail? Y/N

Whom may we thank for referring you? _____
Emergency contact: _____ **Emergency Contact Phone:** _____

Holder of Insurance: if same, circle yes _____ **Relationship to Patient:** _____

Place of Employment: _____ **Occupation:**_____

Address: _____ **Work Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Social Security Number:** _____

Financially Responsible Party: if same circle yes_____ ___ **Relationship to Patient:** _____

PRIMARY INSURANCE **SECONDARY INSURANCE**

Insurance Company and ID number : _____ **Insurance Company:** _____

Primary MD: _____

Specialty	Name	Phone	Fax	Address	Hospital Affil.

Other MD: _____

Specialty	Name	Phone	Fax	Address	Hospital Affil.

Other MD: _____

Specialty	Name	Phone	Fax	Address	Hospital Affil.

Acknowledgement and Authority By my signature below, I consent to treatment as necessary or desirable to the patient named above, including but not restricted to whatever drugs, medicines, laboratory, X-ray or other studies that may be used by the attending physician, nurse, or qualified designates. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full at the time of service unless other arrangements are made. I have read and understand the 'welcome to VPM' information and I agree to the terms contained here in and office rules to the best of my ability. I have read and understand the *financial responsibility form.* I also authorize photograph and videotaping of my progress throughout the course of treatment and for my records only.

Should I find myself under the care of an on-call covering practitioner, I agree to hold him/her not legally medically liable should I choose to engage in holistic or alternative medical practices and treatments with which the practitioner is not familiar or to which he/she does not subscribe. Moreover, if I choose to undertake holistic or alternative treatments with which the practitioners at Vineyard Personalized Medicine are not familiar, or to which they do not subscribe, I will hold them harmless for any ensuing adverse events. Please sign two or three times below and check your desired pace. Xerox insurance cards front and back and send in as well.

All charges made on day or immediately after service is rendered - you will be sent receipt via email or on next visit. We do not bill and wait for payment. Services not covered by your insurance are paid by check or credit card please – a card must be left on file. Fees, all prices subject to change:

- **Phone appointments 500.00 per hour and not billable to insurance.**
- **Cancellations *must be 3 business days in advance* or charged 100 for regular appointments,300.00 for first visit. IV cancellations 100. Allergy testing 50.00 if cancel half day, 100.00 if whole.**
- **Routine short visits covered with Medicare, Mass health, Network Health, Tufts, or UHC will be billed to your plan.**
- **Supplements are 20% off retail but you are encouraged to buy on your own at www.Vitacost or www.emersonecologics.com where you get 15% off with my name as clinician.**
- **Lab specimen explanation, prep, or ship of specimens – urine, saliva, or blood 50-100.00 – depending on complexity.**

I understand and agree to these charges and billing practices and agree to abide by the findings of the courts on Martha's Vineyard in the event I do not pay my bill.

Responsible Party Signature: **1.** _____

Date: _____

I have read and understand the HIPPA Privacy Policy: (read first, keep, and sign) **2.** _____

The following question refers to the number of medical topics I feel comfortable covering during an office visit. I would like to move at this pace during my office visit. (Please circle one.)

SLOW = red (– I get anxious hearing too much info), **MODERATE (yellow),** **FAST (green – very eager to get well ASAP)**

Addendum if doctors requests that you sign A first visit includes 30 minutes of chart review/research time. By signing here I authorize additional research of my condition (if necessary) at the rate of $3.00/minute for the first $90.00. Research time is not reimbursable by insurance. **Optional signature if MD requests:**

3._____

BRIEF PATIENT HISTORY

Date:

Name (last, first):

DOB:

Age:

Current Problems, Worst Symptoms First:
Mold Exposed, circle one: **YES /** No

Medications (Do not say "see other page"):

Past Illnesses / Surgeries (age or year):

Toxic Home, Hobby, Pesticides, Solvents, or Work Exposures:

Travel History (country, month, year):

Musty Basements /Mold Exposure (year, location, severity):

Allergies (medications/supplements):

Anaphylaxis, circle one: **YES /** No
Allergies (environmental e.g. pollens cats):

Social History (cigs, alcohol, drugs, etc.):

Married / Divorced Children's Ages_____
Is anyone else ill in home?_____

Lyme History:
Tick Bite
Treatment:
Testing Results:

Significant Family History of Illness: Age/Age of Death:
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 chemically sensitive? Mild / Moderate / Severe	No
Yes	Are you **EMF** sensitive? Does a 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 tags out of 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 standing 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
Yes	Are you very flexible? Can you bend thumb toward forearm?	No

SYMPTOM SEVERITY RECORD Patient's Name:_____.

Enter today's date in the first available column at top of grid. List all symptoms you've had in the past few days or last appointment in the column on the left. Please rate them on a scale of 0 to 10, with 10 being the worst.

Symptom List	**Date Completed** (Write in on a slant.)																		
	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Nervous/Anxious																			
Irritable																			
Depressed																			
Suicidal																			
Tearful																			
Fatigue																			
Muscle Weakness																			
Joint Pains																			
Headaches																			
Memory Problems																			
Foggy Thinking																			
Chilly/Cold hands/feet																			
Bowel problems																			
Chemical Sensitivity																			
Electrical Sensitivity																			
Allergy Symptoms																			
Sexual Function prob.																			
Libido problems																			
Hrs of Sleep/night																			
Pain																			
Insomnia																			
Fast heart beat																			
Tired after eating																			
Irrit. by clothing tags																			
Reading problems																			
Sick in stores/malls																			
Sensitive to mold																			
Heat intolerance																			
Exercise intolerance																			
Combative behavior																			

From the Office of Lisa Nagy, M.D.
Medical Records Release Authorization

Please list doctors, hospitals, and other medical providers so we may evaluate your records.

	To Provider:	**phone**	**fax**	**date of service**
1.	_____	**( ) -**	**( ) -**	_____
2.	_____	**( ) -**	**( ) -**	_____
3.	_____	**( ) -**	**( ) -**	_____
4.	_____	**( ) -**	**( ) -**	_____
5.	_____	**( ) -**	**( ) -**	_____
6.	_____	**( ) -**	**( ) -**	_____
7.	_____	**( ) -**	**( ) -**	_____
8.	_____	**( ) -**	**( ) -**	_____
9.	_____	**( ) -**	**( ) -**	_____
10.	_____	**( ) -**	**( ) -**	_____

Please send records for the patient listed below to:

Lisa Nagy, M.D.
Vineyard Personalized Medicine
24 Cournoyer Road
Vineyard Haven, MA 02568

Email: vpm@nagy1.com
Dr. cell: (310) 213-5472
Phone: (508) 693-1300
Fax: (508) 693-6400

Patient signature authorizing release: _____

Patient printed name: _____

Patient date of birth: _____

Witness: _____ Date: _____

Adrenal Score Sheet

Circle the number in the right hand column if this symptom describes you. Please compute the total.

name: _____

Excessive fatigue	10
Nervousness and Irritability	9
Mental depression	8
Apprehensions	7
Excessive weakness	5
Light headedness	5
Fainting and fainting spells	4
Insomnia	10
Inability to concentrate	10
Low blood pressure on standing (up)	10
Swollen, tender neck and lymph nodes	10
Thin and dry skin	10
Scanty perspiration	10
Sparse hair	8
Crowded incisors	8
This physical frame	8
Redness of palms	3
Skin turns pale on exposure to cold	2
Low basal body temperature	9
Elevated white blood cells	6
Unexplained circulatory instability (flushing and pallor, blood pressure going up and down) 5	
Abnormally low blood pressure	10
Unusual severity of illnesses	10
High fevers	7
Apathy, depression or fatigue	9
Vitiligo	3
Loss of armpit hair or pubic hairloss	4
Low sex hormone function	5
Low blood sugar	7
Low sodium in the blood	8
High potassium in the blood	8
Low white blood count	7

Total score: _____

Autonomic Nervous System Checklist

Have you had any of the following conditions? Please answer yes or no.

name: _____

Excessive Sweating or difficulty sweating?	Yes	No
Flushing or pink/pale patches of skin?	Yes	No
Migraines or vascular headaches?	Yes	No
Intermittent blurred vision of unknown cause or light sensitivity; dry eyes or excessive tears?	Yes	No
Nasal blockage off and on	Yes	No
Redness of nose	Yes	No
Difficulty digesting; stomach acid, heart burn or GERD; frequent nausea or vomiting	Yes	No
Constipation or recurrent diarrhea	Yes	No
Intestinal spasms or IBS	Yes	No
Excessive or unusually infrequent urination; or difficult bladder control?	Yes	No
Difficulty with sexual function?	Yes	No
Asthma or other inhalant allergies?	Yes	No
Blood pressure unusually frequently up and down?	Yes	No
Blood pressure different from one side of body to the other	Yes	No
Erratic heart rate- sometimes fast, sometimes slow	Yes	No
Raynaud's Syndrome or white or blue finger tips	Yes	No
Heat or cold intolerance; or chilliness	Yes	No
Cold hands and feet?	Yes	No
Faintness on standing or fainting attacks	Yes	No
Excessive or frequent "Fight or Flight "response?	Yes	No

Thyroid Symptom Checklist

Rate: From 1 (mild) to 5 (severe/always) name: _____

	Often Cold – hands, feet (mostly at night)
	Tendency to increase weight
	Often tired/without strength
	Feeling a reduced vitality
	Lazy or drowsy during the day
	Melancholic or depressed
	Absentminded
	Headaches (forehead/back of head)
	Migraines
	Loss of concentration/memory
	Feel nervous/irritable
	Feel sometimes swollen face (face, eyes, or abdomen)
	Suffer from constipation
	Poor or exaggerated appetite
	Slow or difficult digestion
	Can't tolerate fats or chocolate
	Bedwetting as a child
	Regular nosebleeds
	Sometimes short of breath
	Complain of heart palpitations
	Have muscle cramps
	Have varicose veins
	Feelings of poor circulation
	Stiffness/aching joints
	Low back pain
	Allergies/asthma
	Catch colds easily
	Trouble with sore throat/hoarseness
	Ringing in the ears
	Moments of weakness or dizziness
	Dry skin or hair
	Suicidal tendencies
	Lump in throat or difficulty swallowing
	Permanent feeling of heat
	Lose weight although eating
	Feeling of inner trembling/nervous
	Muscles have lost power
	Please total the numbers of your results to the left.

Dietary Questionnaire name: _____

Please indicate the number of times per day, week, or month that the following foods are consumed. Add foods in the empty blocks that you eat very frequently. **Complete only one column per food please.**

FOOD	Times per or day	Times per or week	Times per month	FOOD	Times per or day	Times per or week	Times per month
Beverages				**Grains**			
Alcohol				Bread			
Coffee/decaf				Baked goods			
Tea (regular and decaf)				Crackers			
Sodas (type)				Cold Cereal			
Juice drinks				Cooked Cereal			
Other				Pasta/macaroni			
Desserts				Rice/millet			
Ice Cream/Popsicles				Pancakes waffles			
Candy				Popcorn			
Pastries/Cookies				Pretzels			
Honey				**Produce**			
Sugar				Potato			
Pudding/Jello				Tomato			
Preserves				Catsup			
Artificial sweeteners				Yellow vegetables			
Other sweeteners				Green vegetables			
Protein & fat				Raw vegetables			
Red meat				Salad			
Pork/ Ham				Raw fruit			
Bacon/Sausage				Citrus fruit			
Poultry				Fruit juice			
Fish				Other			
Shell fish				**Miscellaneous**			
Luncheon				Condiments			
Nuts/Seeds				Pickles			
Soy/tofu				Mushrooms			
Beans				Black Pepper			
Milk				Vinegar			
Cheese				Other:			
Yogurt/Kefir/Buttermilk							
Eggs							
Margarine							
Lard							
Shortening							
Vegetable oil							
Mayonaise							
Salad dressing							
Chips & dips							
Peanut butter							

Please describe your food addictions and problems:

Doctor's Notes:

Health Check – Men's Symptom Review

name: _____

Please review the symptom checklist below and indicate any symptoms you are experiencing

Symptom	None	Mild	Moderate	Severe	
Decrease Urine Flow					Estrogen Dominance
Increased Urinary Urge					
Prostate Problems					
Weight Gain – Chest/Hips					Metabolic Syndrome / Low Androgens
Weight Gain – Waist					
Decreased Libido					
Decreased Erections					
Ringing in Ears					
High Cholesterol					
Elevated Triglycerides					
Hot Flashes					
Night Sweats					
Decreased Mental Sharpness					
Increased Forgetfulness					
Decreased Muscle Size					
Decreased Flexibility					
Sore Muscles					
Increased Joint Pain					
Neck or Back Pain					
Bone Loss					
Rapid Aging					
Thinning Skin					
Decreased Stamina					
Burned out Feeling					
Infertility Problems					
Stress					Adrenals
Morning Fatigue					
Evening Fatigue					
Difficulty Sleeping					
Apathy					
Depressed					
Foggy Thinking					
Anxious					
Irritable					
Nervous					
Headaches					
Sugar Cravings					
Dizzy Spells					
Allergies					
Cold Body Temperature					Thyroid / Other
Goiter					
Hoarseness					
Hair Dry or Brittle					
Nails Breaking or Brittle					
Constipation					
Slow Pulse Rate					
Rapid Heartbeat					
Heart Palpitations					

Health Check - Women's Symptom Review

name: _____

Please review the symptom checklist below and indicate any symptoms you are experiencing

Symptom	None	Mild	Moderate	Severe	
Hot Flashes					Low Estrogen
Night Sweats					
Vaginal Dryness					
Incontinence					
Irregular Periods					Estrogen Dominant
Uterine Fibroids					
Water Retention					
Tender Breasts					
Fibrocystic Breasts					
Increased Forgetfulness					
Foggy Thinking					
Tearful					
Depressed					
Mood Swings					
Stress					Adrenals
Morning Fatigue					
Evening Fatigue					
Difficulty Sleeping					
Decreased Stamina					
Anxious					
Irritable					
Nervous					
Ringing in Ears					
Fibromyalgia					
Allergies					
Headaches					
Sugar Cravings					
Dizzy Spells					
Cold Body Temperature					Thyroid
Goiter					
Hoarseness					
Hair Dry or Brittle					
Nails Breaking or Brittle					
Constipation					
Slow Pulse Rate					
Rapid Heartbeat					
Heart Palpitations					
Infertility Problems					Metabolic Syndrome/High Androgen
Acne					
Increased Facial/Body Hair					
Scalp Hair Loss					
Weight Gain-Hips					
Weight Gain-Waist					
High Cholesterol					
Elevated Triglycerides					
Decreased Libido					Low Androgen / Other
Decreased Muscle Size					
Thinning Skin					
Rapid Aging					
Aches & Pains					
Bone Loss					

Date

Chemical Exposures

he following items ask about your responses to various odors or hemical exposures. Please indicate whether or not these odors or xposures would make you feel sick, for example, you would get a eadache, have difficulty thinking, feel weak, have trouble breathing, get n upset stomach, feel dizzy, or something like that. For any exposure hat makes you feel sick, on a 0-10 scale rate the severity of your mptoms with that exposure. For exposures that do not bother you, nswer "0." Do not leave any items blank.

For each item, circle one number only:
[0 = not at all a problem] [5 = moderate symptoms]
[10 = disabling symptoms]

1. Diesel or gas engine exhaust 0 1 2 3 4 5 6 7 8 9 10
2. Tobacco smoke 0 1 2 3 4 5 6 7 8 9 10
3. Insecticide 0 1 2 3 4 5 6 7 8 9 10
4. Gasoline, for example at a service station while filling the gas tank 0 1 2 3 4 5 6 7 8 9 10
5. Paint or paint thinner 0 1 2 3 4 5 6 7 8 9 10
6. Cleaning products such as disinfectants, bleach, bathroom cleansers or floor cleaners 0 1 2 3 4 5 6 7 8 9 10
7. Certain perfumes, air fresheners or other fragrances 0 1 2 3 4 5 6 7 8 9 10
8. Fresh tar or asphalt 0 1 2 3 4 5 6 7 8 9 10
9. Nailpolish, nailpolish remover, or hairspray 0 1 2 3 4 5 6 7 8 9 10
10. New furnishings such as new carpeting, a new soft plastic shower curtain or the interior of a new car 0 1 2 3 4 5 6 7 8 9 10

Total Chemical Intolerance Score (0-100): ____

lame any additional chemical exposures that make you feel ill and core them from 0 to 10: _____

_____

_____

_____

_____

_____

_____

Name:

Other Exposures

The following items ask about your responses to a variety of other exposures. As before, please indicate whether these exposures would make you feel sick. Rate the severity of your symptoms on a 0-10 scale. Do not leave any items blank.

For each item, circle one number only:
[0 = not at all a problem] [5 = moderate symptoms]
[10 = disabling symptoms]

1. Chlorinated tap water 0 1 2 3 4 5 6 7 8 9 10
2. Particular foods, such as candy, pizza, milk, fatty foods, meats, barbecue, onions, garlic, spicy foods, or food additives such as MSG 0 1 2 3 4 5 6 7 8 9 10
3. Unusual cravings, or eating any foods as though you were addicted to them, or feeling ill if you miss a meal 0 1 2 3 4 5 6 7 8 9 10
4. Feeling ill after meals 0 1 2 3 4 5 6 7 8 9 10
5. Caffeine, such as coffee, tea, Snapple, cola drinks, Big Red, Dr. Pepper or Mountain Dew, or chocolate 0 1 2 3 4 5 6 7 8 9 10
6. Feeling ill if you drink or eat less than your usual amount of coffee, tea, caffeinated soda or chocolate, or miss it altogether 0 1 2 3 4 5 6 7 8 9 10
7. Alcoholic beverages in small amounts such as one beer or a glass of wine 0 1 2 3 4 5 6 7 8 9 10
8. Fabrics, metal jewelry, creams, cosmetics, or other items that touch your skin 0 1 2 3 4 5 6 7 8 9 10
9. Being unable to tolerate or having adverse or allergic reactions to any drugs or medications (such as antibiotics, anesthetics, pain relievers, x-ray contrast dye, vaccines or birth control pills), or to an implant, prosthesis, contraceptive chemical or device, or other medical, surgical or dental material or procedure 0 1 2 3 4 5 6 7 8 9 10
10. Problems with any classical allergic reactions (asthma, nasal symptoms, hives, anaphylaxis or eczema) when exposed to allergens such as tree, grass or weed pollen, dust, mold, animal dander, insect stings or particular foods 0 1 2 3 4 5 6 7 8 9 10

Total Other Intolerance Score (0-100): ____

Symptoms

The following questions ask about symptoms you may have experienced commonly. Rate the severity of your symptoms on 0-10 scale. Do not leave any items blank.

For each item, circle one number only:
[0 = not at all a problem] [5 = moderate symptom
[10 = disabling symptoms]

1. Problems with your muscles or joints, such as pain, aching, cramping, stiffness or weakness? MS 0 1 2 3 4 5 6 7 8
2. Problems with burning or irritation of your eyes, or problems with your airway or breathing, such as feeling short of breath, coughing, or having a lot of mucus, post-nasal drainage, or respiratory infections? AIR/MM 0 1 2 3 4 5 6 7 8
3. Problems with your heart or chest, such as a fast or irregular heart rate, skipped beats, your heart pounding, or chest discomfort? COR 0 1 2 3 4 5 6 7 8
4. Problems with your stomach or digestive tract, such as abdominal pain or cramping, abdominal swelling or bloating, nausea, diarrhea, or constipation? GI 0 1 2 3 4 5 6 7 8
5. Problems with your ability to think, such as difficulty concentrating or remembering things, feeling spacey, or having trouble making decisions? COG 0 1 2 3 4 5 6 7 8
6. Problems with your mood, such as feeling tense or nervous, irritable, depressed, having spells of crying or rage, or loss of motivation to do things that used to interest you? AFF 0 1 2 3 4 5 6 7 8
7. Problems with balance or coordination, with numbness or tingling in your extremities, or with focusing your eyes? NM 0 1 2 3 4 5 6 7 8
8. Problems with your head, such as headaches or a feeling of pressure or fullness in your face or head? HEAD 0 1 2 3 4 5 6 7 8
9. Problems with your skin, such as a rash, hives or dry skin? SKIN 0 1 2 3 4 5 6 7 8
10. Problems with your urinary tract or genitals, such as pelvic pain or frequent or urgent urination? (For women: or discomfort or other problems with your menstrual period?) GU 0 1 2 3 4 5 6 7 8

Total Symptom Score (0-100): ____

Name:

— Masking Index —

ıe following items refer to *ongoing* exposures you may be having. rcle "0" if the answer is "NO," or if you don't know whether you ve the exposure. Circle "1" if the answer is "YES," you do have a exposure. Do not leave any items blank.

Circle "0" or "1" only:

1. Do you smoke or dip tobacco once a week or more often? NO=0 YES=1
2. Do you drink any alcoholic beverages, beer, or wine once a week or more often? NO=0 YES=1
3. Do you consume any caffeinated beverages once a week or more often? NO=0 YES=1
4. Do you routinely (once a week or more) use perfume, hairspray, or other scented personal care products? NO=0 YES=1
5. Has either your home or your workplace been sprayed for insects or fumigated in the past year? NO=0 YES=1
6. In your current job or hobby, are you routinely (once a week or more) exposed to any chemicals, smoke or fumes? NO=0 YES=1
7. Other than yourself, does anyone routinely smoke inside your home? NO=0 YES=1
8. Is either a gas or propane stove used for cooking in your home? NO=0 YES=1
9. Is a scented fabric softener (liquid or dryer sheet) routinely used in laundering your clothes or bedding? NO=0 YES=1
0. Do you routinely (once a week or more) take any of the following: steroid pills, such as prednisone; pain medications requiring a prescription; medications for depression, anxiety, or mood disorders; medications for sleep; or recreational or street drugs? NO=0 YES=1

Masking Index (0-10): (Total number of YES answers) ☐

— Impact of Sensitivities —

If you are sensitive to certain chemicals or foods, on a scale of 0-10 rate the degree to which your sensitivities have affected various aspects of your life. If you are not sensitive or if your sensitivities do not affect these aspects of your life, answer "0." Do not leave any items blank.

How much have your sensitivities affected:
[0 = not at all] [5 = moderately] [10 = severely]

1. Your diet? 0 1 2 3 4 5 6 7 8 9 10
2. Your ability to work or go to school? 0 1 2 3 4 5 6 7 8 9 10
3. How you furnish your home? 0 1 2 3 4 5 6 7 8 9 10
4. Your choice of clothing? 0 1 2 3 4 5 6 7 8 9 10
5. Your ability to travel to other cities or drive a car? 0 1 2 3 4 5 6 7 8 9 10
6. Your choice of personal care products, such as deodorants or makeup? 0 1 2 3 4 5 6 7 8 9 10
7. Your ability to be around others and enjoy social activities, for example, going to meetings, church, restaurants, etc.? 0 1 2 3 4 5 6 7 8 9 10
8. Your choice of hobbies or recreation? 0 1 2 3 4 5 6 7 8 9 10
9. Your relationship with your spouse or family? 0 1 2 3 4 5 6 7 8 9 10
10. Your ability to clean your home, iron, mow the lawn, or perform other routine chores? 0 1 2 3 4 5 6 7 8 9 10

Total Life Impact Score (0-100): ☐

For copies of the QEESI call 210-567-7407 or email millercs@uthscsa.edu.

REFERENCES:

Background information:

Chemical Exposures: Low Levels and High Stakes (2nd Ed.) by Nicholas A. Ashford and Claudia S. Miller. John Wiley & Sons, Inc., New York. 1998.

Sensitivity, specificity, reliability and validity of the QEESI:

Miller CS, Prihoda TJ: The Environmental Exposure and Sensitivity Inventory (EESI): a standardized approach for measuring chemical intolerances for research and clinical applications. *Toxicology and Industrial Health* 15:370-385, 1999.

Miller CS, Prihoda TJ: A controlled comparison of symptoms and chemical intolerances reported by Gulf War veterans, implant recipients and persons with multiple chemical sensitivity. *Toxicology and Industrial Health* 15:386-397, 1999.

Date: ID:

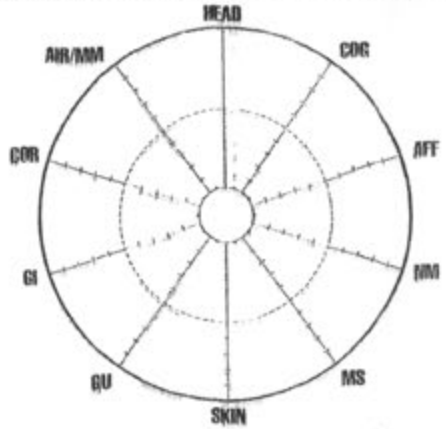
QEESI®

Quick Environmental Exposure and Sensitivity Inventory V-1

The purpose of this questionnaire is to help identify health problem you may be having and to understand your responses to various exposures. Complete pages 1-5, describing how you are now. Then fill in the "target" diagram below.

If your health problems began suddenly or became much worse after a particular exposure event, such as a pesticide exposure or moving to a new home or office building, then go back through page 1-3 and indicate how you were before the exposure event. Use different colors or symbols (circles, squares) for "before" and "after."

Symptom Star



Instructions: Open page 3 so that it lies next to this page. Place a dot on the corresponding spoke for each symptom item. Connect these points. Indicate "before" and "after" scores by using different colors or dotted versus solid lines.

GENETIC RISK ANALYSIS

Please place age at diagnosis where appropriate.	Mother	Father	Brother(s)	Brother(s)	Sister(s)	Sister(s)	Child(ren)	Child(ren)	Child(ren)	Child(ren)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still alive)														
Age at death														
Colon Cancer														
Breast Cancer														
Other Cancers - List Type _____														
Heart Disease														
Stroke														
Hypertension														
Obesity/Overweight														
Diabetes														
High Cholesterol														
Arthritis (<60 years old)														
Multiple Sclerosis														
Rheumatoid Arthritis / Lupus / Psoriasis														
Ulcerative Colitis / Crohn's Disease														
Irritable Bowel Syndrome (IBS)														
Celiac Disease														
Asthma / Chronic Bronchitis														
Eczema/Hives														
Food Allergies or Sensitivities														
Environmental Sensitivities														
Multiple Chemical Sensitivities														
Dementia or Parkinson's														
Substance Abuse (alcoholism, drugs)														
Depression														
Anxiety														
ADHD														
Autism														
Thyroid Disorders														
Other _____														
Other _____														
Other _____														

ALLERGY DATA BASE & HEALTH HISTORY

Please complete the following questionnaire legibly and **COMPLETELY**. This form will become the beginning of your chart, and will help the doctor to determine the cause of your problems. **ALL ITEMS MUST BE COMPLETED.**

Patient's Name: _____ Date this form completed: _____
(LAST) (FIRST) (MIDDLE)

Referred by: _____ Date office visit: _____

Patient's Nickname: _____ Patient's personal physician: _____

Address _____ Sex _____ Age _____

_____ Date of Birth _____
(CITY) (STATE) (ZIP)

Home Phone (____) _____ Bus. Phone (____) _____ Patient Occupation _____

Mother's Occupation _____ Father's Occupation _____

Marital Status (please circle): single married divorced separated widowed

If patient is a child, marital status of parent(s): single married divorced separated widowed

Last school grade completed by patient: _____ If child, lives with: _____

Mother's Name: _____ Father's Name: _____

Name of individual responsible for bill: _____

_____
(STREET) (CITY) (STATE) (ZIP)

Employer: _____

Ins. Co. _____ If Medicare, # _____

Certificate/Policy # _____

SYMPTOMS/PROBLEMS:

Concisely list your symptoms/problems, i.e.: Why did you come to this office? What is bothering you? Explain if there is a pattern to the symptoms. Date symptoms/problems first recognized by patient. Score them 1-5. 1 = least bothersome, 5 = most bothersome.

MEDICATIONS

A. List any medications, their specific names, dosage, and how often **currently** taken. (Show brand names)

_____
_____
_____
_____
_____
_____

B. List any vitamin, mineral or nutritional supplements, their specific names, dosage, and how often **currently** taken. (Show brand names)

_____
_____
_____
_____
_____
_____

Do you take any of these daily or as often as 1-2 times a week?	YES	NO
Aspirin or Acetaminophen (Datril, Tylenol, etc.)		
Ibuprofen (Advil, Nuprin)		
Sinus or allergy medications		
Laxatives		
Antacids		
Nose drops/sprays		
Ointments		
Antidepressants		
Nebulizers		
Other drugs		

List any medications to which you are allergic or which cause unpleasant side effects. Please describe reaction:

Have you ever taken an oral cortisone preparation such as Prednisone, Decadron, Medrol or others?

	YES	NO	DON'T KNOW	COMMENTS
about a week				
about two weeks				
about a month				
two months or more				
Have you received cortisone type "allergy shots" such as Depo Medrol, Decadron, Kenalog, or others?				
once				
twice				
three				
four or more				
Have you ever been on birth control pills?				
yes, but less than six months				
six months to two years				
more than two years				
are you taking them now?				
any side effects?				
The approximate total amount of time that you have been on Tetracyline, Ampicillin, Keflex, Ceclor, Erythromycin, or other antibiotics (for any reason)				
one month or less				
one month to six months				
six months to two years				
two years or longer				
The medical reasons for which you have taken the antibiotics listed above include (select all applicable):				
Acne or other skin infection				
Kidney, bladder, prostrate, or other urinary tract infections				
Ear infections				
Tonsillitis				
Strep throat				
"Colds"				
Surgically related problems				

Have symptoms occurred in the following patterns in the past year?

	YES	NO	COMMENTS
Worse indoors			
Improved outdoors			
Increase in symptoms within 30 minutes after going to bed			
Symptoms recur or increase with return of cold weather			
Nasal symptoms with little or no itching of eyes			
Worse in air conditioning			
Symptoms increase or occur while dusting or sweeping			
Symptoms are worse outdoors 4:30-8:30 p.m.			
Symptoms increase in cooling evening air			

	YES	NO	COMMENTS
Symptoms are worse in damp places			
Nasal symptoms without eye itching while mowing grass or playing on lawn			
Worse raking leaves or playing in leaves			
Worse September to heavy (killing) frost			
Symptoms increase around October 1st			
Runny nose, sneezing, eye or nose itching			
Itching of the whole eye			
Itching of the inside corners of the eye only			
Symptoms worse on clear days			
Worse outdoors 7-11:00 a.m.			
Improved indoors, especially in air conditioning			
Flare when going from air conditioned room to open air			
Little or no symptoms when it is raining			
Worse in basements			
Symptoms are worse around feed mills			
Symptoms are worse in barns			
Symptoms are worse in certain homes			
Whose home?			
React to cats or in home with cats			
React to dogs or in home with dogs			
React to other animals			
Which?			

Do you usually have **ANY** symptoms to **ANY** degree in these months?

	YES	NO	DON'T KNOW		YES	NO	DON'T KNOW
January				July			
February				August			
March				September			
April				October			
May				November			
June				December			

What 2 consecutive months are your symptoms the least bothersome? List: _____

What 2 consecutive months are your symptoms the most bothersome? _____

If the above 2 questions cannot be answered, are your symptoms the same year round? ☐ Yes ☐ No

HOME ENVIRONMENT	YES	NO
House # years old		
Apartment		
Mobile Home		
In a wooded area		
On a farm		
Garage - attached		
detached		
breezeway		
Basement - dry		
damp		
musty		
ever flooded?		
Crawlspace		
How long have you lived in your present home?		
Have there ever been animals in the home?		
Have the pets been treated for fleas?		
Did this cause any symptoms?		

List current pets:

_____

_____

ow long have they been present?

_____

_____

HOME ENVIRONMENT: (continued)	YES	NO
Please list past pets and what years they were in the home:		
Have you used moth balls/crystals?		
Did this cause any symptoms?		
Any insulation done?		
Type: fiberglass		
cellulose (ground up newspapers, blown in)		
sawdust		
styrofoam		
UFFI (ureafoam)		
formaldehyde insulation		
other		
year done		

HOME ENVIRONMENT (continued)		YES	NO
Heat delivered by:	Forced air		
	Gravity		
	Radiators		
	Electric panels		
Air Filter:	Fiberglass		
	Electronic		
	HEPA		
	Other		
Humidifier:	On furnace		
	Room unit		
Air conditioning:	Whole house		
	Room units		
Air purifier:	Brand		
	What rooms		
Smoking:	Patient (now)		
	Spouse		
	Mother		
	Father		
	Cigarette		
	Cigar		
	Pipe		
Have you stopped smoking and when?			
Have your lawn, trees or shrubs been sprayed or treated chemically?			
Any symptoms after?			

If yes, what symptoms?

		YES	NO
Type of drinking water:	Well water		
	City water		
	Other		
Type of carpet:	Synthetic		
	Wool		
	Cotton		
	Other		
	Rubber/plastic padding		
	Natural fiber padding		
Type of floors in the home:			
Hardwood			
Plywood			
Slab concrete floors			
Any room in which symptoms are worse?			

Which?

Family hobbies:

List any new furnishings:

List any rooms with new carpet:

Appliances:	Gas	Electric
Stove		
Water heater		
Clothes dryer		

Heating System:	YES	NO	
Gas			
Fuel oil			
Coal			
Electric			
Wood burning fireplace			
Wood burning stove			
Steam			
Space heater			
Type:			
Other			

BEDROOM:		YES	NO	
Mattress:	Regular			
Mattress cover:	Cotton			
	Allergy Proof			
Pillow:	Feather			
	Foam Rubber			
	Dacron			
	Other			
Covers:	Wool			
	Cotton			
	Synthetic			
	Down			
Bedroom carpeted?				
Stuffed animals?				
Does child sleep with these?				
Has your home been recently painted?				
Any recent remodeling?				

Describe:

	YES	NO
Have you been away from your home or your environment in the last several years?		
If yes - where?		
When away, were there any changes in your symptoms?		
If better to what degree?		
If walking on an ocean beach, were you symptom free?		

WORK ENVIRONMENT:	YES	NO	
At work, are your symptoms			
better			
worse			
the same			
Are you bothered by smoking in your work place?			
Any particular place or room at work which bothers you?			
Have you been exposed to any of the following items at work presently or in previous jobs?			
Asbestos			
Chemicals			
Fumes			
Mists (like spray paints)			
Biologics (blood, serum, etc.)			
Dusts (grain, cotton)			
Agricultural sprays			

	YES	NO	
Do you think your work and/or machines have anything to do with your symptoms?			
Are there materials used at work that you think have something to do with your symptoms?			
Describe these materials and/or machines/equipment			
How long at this employment?			
How many miles do you travel to work?			
by expressway miles?			
sideroad miles?			

MISCELLANEOUS:	YES	NO	
Do you suspect sensitivity to:			
Latex			
Insect Venom			

OTHER ENVIRONMENTAL QUESTIONS	YES	NO	IF YES, WHAT SYMPTOMS?
Do you notice an increase in symptoms in:			
church			
malls or shopping centers			
school			
particular classroom			
car			
gas station			
beauty parlor, hair stylist			
fabric store			
carpeting store			
hospital			
other			

Do these products bother you?	YES	NO	IF YES, WHAT SYMPTOMS?
Gasoline products			
Exhaust fumes			
Soaps, detergents			
Fabric softeners			
Bleaches			
Chlorinated water			
Ammonia			
Polishes, floor waxes			
Insect sprays			
Mosquito spray			
Moth balls			
Asphalt, tar			
Disinfectant, sprays - liquid			
Rubber products			
Varnish, paint, shellac			
Hair sprays			
Cosmetics			
Perfumes			
Newsprint			
Tobacco Smoke			
Metals			
Nickel			
Mercury			
Inexpensive earrings			
Other			

WEATHER-RELATED	YES	NO	IF YES, WHAT SYMPTOMS?
Worse with storm front			
Worse with wind (from which direction)			
Worse on rainy day			
Worse on dry day			
Other			

FOODS

Are you on any special diet at the present time:

	YES	NO	
Rotation			
Vegetarian			
Low salt			
Pritikin			
Weight Reduction			
Low Cholesterol			
Diabetic/Hypoglycemic			
Stone Age Diet			
Other			
Are you excessively sleepy after meals?			
Do you notice itching			
of the roof of the mouth?			
between the shoulder blades?			
inside the ear canal?			
and/or rash inside the bend of the elbows or behind the knees?			
of the rectum?			
of the nose?			
Do you get hives?			
Do you get canker sores?			
Have a foul breath odor?			
Are you bothered by			
belching			
gas			
stomach ache			
nausea			
vomiting			
bloating			
constipation			
diarrhea			
Do you retaste foods after you have eaten them?			
Which foods?			

Do you:	YES	NO	
Notice increased symptoms 5 to 60 minutes after meals			
Awaken from sleep between 1:00 to 5:00 a.m.			

If answer above is yes, is there any specific food you are hungry for at that time?

When sitting or standing, do you ever consciously notice that one side of your nose is blocked and the other side less so?			
And that later it is the reverse?			

Please list any foods you avoid. Explain why you avoid them.

Please list any foods you eat excessively, i.e. once daily or more often.

Which food would you miss most if taken out of your diet?

Please list alcoholic beverages you drink and how often.

CANDIDA	YES	NO
On antibiotics, frequently in past?		
How long ago?		
List any side effects (example: diarrhea)		
Frequent vaginal infections, yeast infections, or infection of the prostate gland?		
When on antibiotics, is there an increase in vaginal or prostate symptoms?		
Rectal itching?		
Frequent fungal infections of nails?		
Other fungal infections?		
Thrush?		
Ringworm?		
Jock itch?		
Athlete's foot?		
Other skin signs?		
Cracked or split nails?		

	YES	NO
Fingertips?		
Cuticles?		
Callouses?		
Do you crave sugar?		
Do you crave breads?		
Do you crave pastries?		
Do you have symptoms when you drink alcoholic beverages?		
What symptoms?		
Are you bothered by premenstrual syndrome?		

If answer to previous question is YES, how does PMS bother you?

ALLERGY TREATMENT HISTORY

	YES	NO	COMMENTS
Have you ever had allergy tests for airborne inhalants? (Please attach a copy of the test results if you received a copy.)			
Type: Intradermal (injection by needle into skin)			
Prick (the skin is just "poked")			
Scratch			
RAST (blood test)			
Other			
When: Within the last year			
1-2 years ago			
3-5 years ago			
6 or more years ago			
What doctor(s)?			
Are you taking allergy injections now? (Select most accurate answer and tell for how long)			
More often than once a week			
Once a week			
Every two weeks			
Monthly			
Seasonally, as needed			
How long have you been receiving allergy injections?			
Date of last dose			
Did you see improvement with the shots?			
Have you ever taken allergy injections in the past?			
When was the first dose?			
Do you or did you have arm reactions?			
Have you ever been tested for food allergies? (Please attach a copy of the test results if you received a copy.)			
Type: Never			
Elimination or rotary diet			
Sublingual test (under the tongue)			
Intradermal (injection with syringe)			
Prick (the skin is "poked")			
Scratch			
Patch			
RAST (blood test)			
Cytotoxic Test or ALCAT Test			
Other			
When: Within the last year			
1-2 years ago			
3-5 years ago			
6 or more years ago			
What doctor(s)?			
Type of treatment: A rotary diversified diet			
Elimination diet			
Sublingual therapy			
Shots			

	YES	NO
Can you have a good nights rest, wake up in the morning and still feel tired?		
Do you have problems with short term memory?		
Do you have greater emotional swings than what you think you should. [By this we mean emotional stimulation (your ups) or emotional depression (your downs).]		
Do you not tolerate the cold? i.e. (Do you need to wear more clothes than others in order to stay warm?)		
Do you think your reflexes (your neuromuscular responses) are as quick as they used to be?		
Are you gaining more weight than you think you should for your calorie intake?		

Please record your basal temperature. (What is your temperature before you get out of bed in the morning?)

Oral_____ OR Rectal_____ OR Axillary_____

If you do not know, please take your temperature.

HEALTH HISTORY

	Patient	Spouse	Mother	Father	Brothers/Sisters	PLEASE EXPLAIN SPECIFIC DIAGNOSIS
Allergies						
Asthma						
Birth defects						
Blood diseases (anemia, hemophilia, etc.)						
Bone or joint disorders						
Cancers, tumors, malignancies						
Chronic lung diseases (asthma, T.B., etc.)						
Eye or ear disorders						
Glandular diseases (thyroid, diabetes, etc.)						
Heart trouble						
Kidney or urinary disease (bladder problems, cystitis)						
Mental retardation						
Muscle disease (weakness, poor control)						
Nerve disease (epilepsy, cerebral palsy, others)						
Psychiatric condition						
Vaginal discharge, yeast infection						
Venereal disease (S.T.D.)						
HIV Positive -- AIDS						
High blood pressure						
Gastro-intestinal disorders (ulcers, diverticulitis, Crohn's disease, irritable bowel syndrome, colitis)						
Skin disorders (eczema, psoriasis, rashes)						
Liver disease (hepatitis, cirrhosis, jaundice)						
Mononucleosis						
Polio myelitis						
Coxsackie virus						
Herpes						
Migraine headaches						
Alcoholism						
Other						

Major hospitalizations: If you have ever been hospitalized for any medical illness or operation, write down your most recent hospitalizations below.

	YEAR	OPERATION OR ILLNESS	NAME OF HOSPITAL	CITY AND STATE
1st hospitalization (most recent)				
2nd hospitalization				
3rd hospitalization				

Outpatient surgery:

	YEAR	OPERATION OR ILLNESS	NAME OF HOSPITAL	CITY AND STATE
1st surgery (most recent)				
2nd surgery				
3rd surgery				

Test results:

	YES	NO	DON'T KNOW	YEAR	RESULTS
Chest X-ray					
Kidney X-ray					
G.I. series					
Colon X-ray (barium enema)					
Gallbladder X-ray					

HEALTH HISTORY (continued)

	YES	NO	DON'T KNOW	YEAR	RESULTS
EKG					
EEG					
Immunoglobulins					
Any other studies					

Past diseases:

	YES	NO	DON'T KNOW	YEAR	PROBLEMS
Chicken pox					
Mumps					
Hepatitis					
Croup					
Chronic bronchitis					

	YES	NO	DON'T KNOW	YEAR	PROBLEMS
Measles					
German measles (3 day)					
Rheumatic fever					
Whooping cough					

	YES	NO
Have you ever received a blood transfusion?		
If yes, when?		
Have you been outside the continental U.S. in the past 5 years?		
If yes, where?		

Date of last physical exam _____ Done by _____

Explain any abnormal finding(s) _____

OVERALL HEALTH REVIEW (please mark any symptoms that apply)

Central nervous system:

	YES	NO	COMMENTS
Headaches:			
Age onset			
Duration			
How many days per month do you have headaches?			
Do they interfere with sleep?			
Do you have to go to sleep for the headache to go away?			
Type:			
Pulsating			
Constant			
Severe			
Migraine			
Relieved by aspirin			
Relieved by other			

	YES	NO	COMMENTS
Aggravated by:			
Cigarettes			
Cold drinks			
Beer or liquor			
Food			
Frequency:			
Regular			
Periodic			
Related to menstrual cycle			
Time of year:			
Anytime			
Fall			
Spring			
Summer			
Winter			
Daytime			
Night time			
Interferes with sleep			

HEALTH HISTORY (continued)

Central Nervous System (continued):

	Yes	No	Comments
Fainting			
Depression			
Mood swings			
Hyperactivity			
Irritability			
Hallucinations			
Forgetfulness/poor memory			
Spacey feeling			
Poor concentration			
Apathy			
Confusion			
Seizures			
Jekyll & Hyde personality			
Panic Disorder			
Sleep Apnea			
Insomnia			
Nightmares			
Sleepiness			
Feeling of rage			
Learning disorders			
Numbness & tingling			
Anxiety (panic)			
Dizziness			
Listlessness			
Fatigue			
On arising			
After meals			
All the time			

Eyes

	Yes	No	Comments
Itching			
Burning			
Pain			
Tearing			
Red eyes			
Sensitive to light			
Puffy eyes			
Dark circles under			
Visual difficulties			
Other			

Ears

	Yes	No	Comments
Itching			
Full, blocked, ear pressure			
Frequent ear infections			
Recurrent fluid behind eardrums			
Reddening of ears			
Earaches			
Sensitive to sound			
Hearing loss			
Dizziness			
Other			

Nose

	Yes	No	Comments
Sneezing spells			
Itching			
Stuffy			
Runny			
Post nasal drip			
Sinusitis			
Sinus pressure/pain			
Nosebleeds			
Nasal polyps			
Rub nose upwards			
Snoring			
Other			

Throat

	Yes	No	Comments
Itching			
Sore			
Tight			
Swollen			
Difficulty swallowing			
Choking			
Hoarse voice			
Frequent clearing of throat			
Post-nasal drainage			

Mouth-teeth-gums

	Yes	No	Comments
Increased salivation			
Bad breath			
Dental problems (Explain)			
Problem with anesthetic			
T.M.J.			
Coated tongue			
Canker sores			
Gum disease			
Tongue or lip swelling			

Breathing

	Yes	No	Comments
Coughing			
Wheezing (only with infection			
Wheezing (other times)			
Chest feels tight			
Not enough air			
Rapid breathing			
Short of breath			
Sleeps with number of pillows			

Gastrointestinal

	Yes	No	Comments
Appetite			
Good			
Poor			
Selective			
Stomach aches			
Cramps			
Intestinal gas			
Inordinate hunger/thirst			
Nausea			
Vomiting			
Fullness/bloating			
Constipation			
Diarrhea			
Foul odor - stool			

Heart-Vascular

	Yes	No	Comments
Rapid or irregular pulse			
Heart murmur			
Chest pains			
Rheumatic fever			
Other heart disease			
Sweating			
Chilly feeling			
Puffy face			
Cold hands/feet			

Bruising

	Yes	No	Comments
Spontaneous			
Easily			
Often			

Blood Pressure

	Yes	No	Comments
High			
Low			

Skin

	Yes	No	Comments
Flushing			
Pallor - white			
Acne			
Dryness			
Oiliness			
Dandruff			
Athlete's foot			
Itching			
Sores, infections			
Vitiligo			
Rashes			
Describe:			
Excessive/offensive body odor			

Muscles and Joints

	Yes	No	Comments
Arthritis			
Bursitis			
Fibrositis			
Joints (aching or pain)			
Neck			
Upper back			
Lower back			
Legs			
Seasonal			
Continuous			
Swelling			
Other			
Weakness			
Shakiness			

Kidney and Bladder
Urination

	Yes	No	Comments
Painful			
Delayed			
Prolonged			
Frequency of:			
Daytime			
Night time			
Urgency			
Bed wetting			
Leaking of urine			
Frequent bladder infection			

Penile, vaginal organs

	Yes	No	Comments
Sores			
Itching			
Yeast infections			
Menstrual irregularities			
Pre-menstrual syndrome			
Impotence			
Loss of libido			
Discharge			
Describe:			

Swelling

	Yes	No	Comments
Generalized			
Hands			
Fingers			
Ankles			
Intermittent			
Continuous			

Lymph

	Yes	No	Comments
Swollen, tender glands			

Stress

	Yes	No	Comments
Home			
Mild			
Moderate			
Severe			
Work			
Mild			
Moderate			
Severe			
School			
Mild			
Moderate			
Severe			

Miscellaneous

	Yes	No	
Do you live near high tension lines?			
Do you live close to a freeway?			
Do you travel by air frequently 12 or more times a year?			
Do you exercise daily			
3 or more times a week			
Is your car less than 2 years old?			
List the primary and secondary industries of the area:			

PARENT, PLEASE FILL OUT THIS PAGE, FOR INFORMATION ON YOUR CHILD.
ADULTS, PLEASE FILL OUT THIS PAGE, FOR YOUR INFANCY, IF THE INFORMATION IS AVAILABLE TO YOU.

Patient's birth history

	YES	NO	DON'T KNOW
During the pregnancy with patient, did mother			
Have high blood pressure?			
Have diabetes or sugar in her urine?			
Have albumin or protein in her urine?			
Have a urinary infection?			
Have German (3 day) measles?			
Take medicines prescribed by her doctor?			
Frequently smoke cigarettes?			
If YES, about how many packs a day?			
Have a venereal disease such as gonorrhea or syphilis?			
Have a dependence on drugs or alcoholic beverages?			
If YES, please explain:			
Other conditions:			
How long was pregnancy?			
How early did mother start seeing the doctor?			
Did patient have hiccups while in mom's uterus?			
Was this patient premature?			
Was more than one baby born?			
Did mother have a difficult delivery?			
Was it a breech (bottom first) delivery?			
Was it a cesarean delivery?			
What was patient's weight a birth?			
Was there an Rh problem?			
Was anything wrong with patient at birth?			
If YES, what?			

Maternal and family history of patient

How many children have you (mother) had?
Which one is this child?
Have you (mother) had any premature births?
Have you (mother) had any cesarean births?
Have you (mother) had any miscarriages?
Mother's age now:
Father's age now:
Mother's height:
Father's height:
Number of people living in child's home:
Who spends most time caring for child (father, mother, etc.)?

Introduction of foods:

1) Was this patient breast or bottle fed? _____

2) Failure to gain or excessive weight gain? _____

3) If bottle fed, what formula did you use? _____

4) Did you need to switch formulas for any reason? _____

List formulas tried and reasons for changing each formula: _____

_____

_____

_____

_____

5) At what age did patient begin solid foods? _____

6) Did patient have any problems with any solid foods introduced? _____

If yes, list the foods and the problems noticed: _____

_____

7) List any foods omitted from the diet during early childhood or infancy. If omitted, why?

_____

_____

_____

_____

_____

_____

_____

_____

Chronological History name: _____

Prenatal				