Vis Clinic
Nutritional and Naturopathic Medicine Comprehensive History (Adult)

Please complete the following questionnaire as thoroughly as possible to aid Vis Clinic in their diagnosis and treatment. This will become a part of your confidential medical record and will not be released unless you have authorized us to do so. Please draw a line through or write **"NA"** in those sections, which do not apply.
PLEASE PRINT CLEARLY.

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Age: _____ Gender: M F

Present Health Concerns (in order of importance): Duration/Severity:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____
8. _____ _____

What types of therapies have you tried for these problem(s) or to improve your health:

☐diet modification ☐fasting ☐vitamins/minerals ☐herbs ☐homeopathy ☐chiropractic ☐acupuncture
☐Conventional drugs ☐Other _____
Explain Results: _____
_____
_____

Childhood History:

Major childhood illnesses: _____
Major problems during childhood: _____
Problems at childbirth: _____
Long Term Medications used in Childhood: _____
☐Breast fed ☐Bottle fed

Immunization History:

Have you had all childhood immunizations? Y/N Any negative reactions? _____
Is Immunization status current? Y/N explain: _____
Do you receive flu shots? _____
Have you received anthrax or small pox vaccination? _____
Foreign Travel Immunization History: _____

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Outpatient Procedures/ Surgeries:

Type (of surgery):	Date:	Reason for Procedure/Admission:	Outcome/Results:
Tonsils			
Ear Tubes			
Appendectomy			
Hysterectomy			
Hernia			
Gallbladder			
Heart Bypass			
Orthopedic			
Cancer (Region)			
Other:			

Major Illnesses/ Injuries –Accidents/Hospitalizations:

Type:	Date:	Treatment Received:	Outcome:
Head Injury			
Neck Injury			
Back/Spine Injury			
Mental Hospitalizations			
Broken bone(s)			
Infections			
Other:			

Dental History:

How many metal filling do you currently have? _____
Have your metal filling been removed? _____
Have you had a root canal Y or N; If yes how many? _____
How would you describe your dental health? _____

Allergies:

□ Penicillin □ Sulfa □ Aspirin □ Codeine □ Other Antibiotics _____ □ Other Medicines_____
□ Foods _____
□ Environmental (Grass/Pollens/Fragrances/Chemicals): _____

Chemical Exposures:

Are you sensitive to chemical smells? _____ List any chemicals, fumes, and dusts, etc that you are or have been repeatedly exposed to: _____
Is your job associated with potentially harmful chemicals (e.g., Pesticides, Solvents, Herbicides, Radioactivity, Smoke):
_____

Social History: (Please circle, or complete if applicable)

Single Married Significant Other Name of Spouse: _____
Your Occupation: _____ Your Education: _____
Hours of Work/ Day/ Week: _____ History of Night work (graveyard shifts): Y/N explain: _____
Children (Sex/Ages/): _____
What is your predominate emotion(s)? _____
Are you in a supportive relationship?_____

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Diagnostic Imaging Performed:

Procedure	Date	Outcome
Chest X-ray		
EKG		
Colonoscopy		
Upper GI Series		
Barium Enema		
Pet Scan		
MRI or CT of the Brain		
MRI or CT of the Abdomen		
MRI or CT of the Spine		
Bone Scan		
DEXA		
Spine X-ray		
Other:		

Laboratory Procedures Performed:

Procedure	Date	Outcome
Blood Chemistries		
Urine Chemistries		
Stool Analysis		
Hair Analysis		
Lipids (Cholesterol, Triglycerides, LDL, HDL)		
Other:		

Medications: prescription and over-the-counter, that you are NOW taking

Name of Drug	Reason for Drug	Dose (mg/etc)	For How Long	Prescribing Dr.
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

How many times and at what ages have you taken:

	Infancy	Childhood	Teen	Adulthood
Antibiotics:	_____	_____	_____	_____
Steroids:	_____	_____	_____	_____

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Vitamins/Herbs/Supplements that you are NOW taking:

Name/Type	Reason for Taking	Dose/day (mg/etc)	For How Long	Who Prescribed
□Multivitamin-mineral				
□Vitamin C				
□Vitamin E				
□EPA/DHA (fish oils)				
□Evening Primrose/GLA				
□Calcium				
□Magnesium				
□Zinc				
□Minerals				
□Probiotics (friendly flora)				
□Digestive enzymes				
□Amino Acids				
□CoQ10				
□Antioxidants (e.g., lutein, resveratrol, etc.)				
□Herbs				
□Homeopathy				
□Protein shakes				
□Super foods (e.g., bee pollen, greens drink etc.)				
□Liquid meals (Ensure)				
Other: _____				
_____				
_____				
_____				
_____				
_____				

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Medical History-Review of Systems: Check if you **Now** Have, **OR** if you **Previously Have Had** any of the following

Condition/Signs/Symptoms	Past	Current	Explain
□Arthritis			
□Allergies			
□Asthma			
□Alcoholism			
□Alzheimers			
□Autoimmune disease(s)			
□Blood pressure problems			
□Bronchitis			
□Cancer			
□Chronic fatigue syndrome			
□Carpel tunnel syndrome			
□Cholesterol elevated			
□Circulatory problems			
□Colitis			
□Dental problems			
□Depression			
□Diabetes			
□Diverticular disease			
□Drug addiction			
□Eating disorder			
□Epilepsey			
□Emphysema			
□Eyes, Ears, Nose, Throat problem(s)			
□Fibromyalgia			
□Gastroesophageal reflux			
□Genetic Disease			
□Glaucoma			
□Heart disease			
□Infection (Chronic)			
□Inflammatory Bowel Disease			
□IBS			
□Kidney or bladder disease			
□Learning disabilities			
□Liver or gallbladder disease			
□Mental illness			
□Migraines			
□Neurological problems (Parkinson's, Paralysis)			
□Sinus problems			
□Stroke			
□Thyroid trouble			
□Obesity			
□Osteoporosis			
□Pneumonia			
□Sexually Transmitted disease			
□Seasonal affective disorder			

□Skin problems			
□Tuberculosis			
□Ulcer			
□Urinary Tract Infections			
□Varicose Veins			

Medical (Men):

Condition/Signs/Symptoms	Past	Current	Explain
□BPH			
□Prostate Cancer			
□Decreased sex drive			
□Infertility			
□STD			
□Other			

Medical (Women):

Date of last GYN exam _____ Mammogram □+ □- PAP □+ □-
Form of Birth control _____ # of Children _____ # of Pregnancies _____
□C-Sections(s) _____
Are you pregnant? _____ if yes, how far along are you? _____
Age of first period _____ Date – last menstrual cycle _____ Length of Cycle _____ days
Interval of time between cycles _____ days
Any recent changes in normal menstrual flow (e.g., heavier, large, clots, scanty) _____
□Surgical Menopause _____ □Menopause _____ (Age entering menopause)

Medical (Women): Cont..

Condition/Signs/ Symptoms	Past	Current	Explain
□Menstrual irregularities			
□Endometriosis			
□Fibrocystic Breasts			
□Fibroids			
□Ovarian cysts			
□PMS			
□Breast Cancer			
□Pelvic inflammatory disease			
□Vaginal infections			
□Decreased sex drive			
□Infertility			
□STD			
□Other			

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Family History:

(Using the following key, designate which family members have had the following. List type where parentheses are present):

P = Parents S = Siblings G = Grandparents C = Children

Condition	Who	Condition	Who
□Allergies		□Epilepsy	
□Alcoholism		□Heart Disease	
□Alzheimers		□High Blood Pressure	
□Anemia		□High Cholesterol	
□Arthritis (Rheumatoid)		□Kidney disease	
□Arthritis (Osteo)		□Mental Disorder ( )	
□Asthma		□Neurological Disorder	
□Auto Immune Disease		□Obesity	
□Bleeding Tendency		□Osteoporosis	
□Diabetes		□Stroke	
□Depression		□Suicide	
□Drug addiction		□Thyroid (Low / High)	
□Cancer ( )		□Liver disease	
□Cancer ( )		□Other: ( )	
□Tuberculosis			

Health Habits:

Tobacco:		**Exercise**	**Nutrition and Diet**
□Cigarettes	#/day	□5-7 days per week	□Mixed food diet
□Cigars	#/day	□3-4 days per week	□Vegetarian
Alcohol:		□1-2 days per week	□Vegan
□Wine	# of glasses/day or week	□45 minutes or more duration per workout	□Salt restriction
□Liquor	# of glasses/day or week	□30-45 minutes duration per workout	□Fat Restriction
□Beer	# of glasses/day or week	□less than 30 minutes duration per workout	□Starch/Carbohydrate restriction
Caffeine:		□ walk ____ #days/wk	□Total calorie restriction
□Coffee	# 6oz cups/day	□ run, jog, other ____ #days/wk	**Specific food Restrictions:**
□Tea	# 6oz cups/day	□ weight lift ____ #days/wk	□Dairy □Wheat □Eggs □soy □corn □all gluten □other
□Soda with Caffeine	# 12oz bottles/cans/day	□ stretch ____ #days/wk	
□Other Sources of Caffeine		□other	
Water:	# glasses/day		

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Food Frequency	**Eating Habits**
# of Servings per day:	□ Skip Meals (which ones):
Fruits:	□One meal/day
Dark green or deep yellow/orange vegetables:	□Two meals/day
Grains (unprocessed):	□Three meals/day
Beans, Peas, Legumes:	□Graze Small frequent meals
Dairy:	□Generally eat on the run
Eggs:	□Eat constantly whether hungry or not
Meat:	
Poultry:	
Fish:	

Eliminations (Stool and Urine):

Bowel Movement Habits		**Urine Habits**	
Frequency: (How Often) Twice/Day, Every Week...		Frequency: (How Often per 24 hour period)	
Color: (Black, brown, yellow, green, white)		Color: (Dark yellow, light yellow, green, colorless)	
Consistency: (Hard, soft, formed, watery)		Character: (Clear, cloudy, concentrated, dilute)	
Any mucus or blood on stool? (which?)		Any blood or sediment? (which?)	
Does stool pass easily?		Any pain, incontinence, or other urinary symptoms?	

Sleep Habits:

How many hours/ night? _____ Does sleep refresh you? _____ If not, why?_____
What time do you usually go to sleep? _____ What time do you usually wake up? _____
Do you have problems: Falling Asleep Staying Asleep Waking up in the Morning
If you wake up during the night, how often and what time does this happen? _____

Do you experience any of these general symptoms EVERY DAY?:

□ Debilitating fatigue □ Depression □ Disinterest in sex □ Disinterest in eating □ Shortness of breath
□ Panic attacks □ Headaches □ Dizziness □ Insomnia □ Nausea □Vomiting □ Diarrhea □ Constipation
□ Fecal Incontinence □Urinary incontinence □Low grade fever □ Chronic pain/inflammation □ Bleeding
□ Discharge □ Itching/rash □ Suicidal thoughts □ Chest pain

Energy Level: (Average Per Week) Circle One

1 2 3 4 5 6 7 8 9 10
(Lowest Energy) **(Highest Energy)**

Do you consider yourself: □underweight □overweight □just right your weight today _____
Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Stress Level: (Average Per Week) Circle One

1 2 3 4 5 6 7 8 9 10
(Lowest Stress) **(Highest Stress)**

Identify the major causes of stress (e.g., changes in job, work, finances or residence; legal problems, relationships):
_____
How do you cope with stress? _____
Who do you talk to about your problems? _____
Who else might you confide in, or seek advice from? _____
What do you do for fun and how often? _____
_____

I Would Like To:

ENERGY –VITALITY
□ Feel more vital
□ Have more energy
□ Have more endurance
□ Be less tired after lunch
□ Sleep better
□ Be free of pain
□ Get less colds and flu
□ Get rid of allergies
□ Not be dependent on over the counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
□ Stop using laxatives and stool softeners
□ Improve sex drive

BODY COMPOSITION
□ Lose weight
□ Burn more body fat
□ Be stronger
□ Have better muscle tone
□ Be more flexible

STRESS, MENTAL, EMOTIONAL
□ Learn how to reduce stress
□ Think more clearly and be more focused
□ Improve memory
□ Be less depressed
□ Be less moody
□ Be less decisive
□ Feel more motivated

LIFE ENRICHMENT
□ Reduce risk of degenerative disease
□ Slow down accelerated aging
□ Maintain a healthier life longer
□ Change from a "treating illness" orientation to creating a wellness lifestyle

What level of change to your living habits are you willing to make to improve your health? (Circle One):

Whatever it takes Significant change Some change No change

What are your current Health GOALS?_ _____

_____
_____
_____