SYNERGY HEALTH CARE

COMPREHENSIVE ADULT HEALTH
HISTORY ASSESMENT FORM

Please read and answer all questions as completely as possible and to the best of your ability. It is **essential** to have a detailed evaluation of your symptoms and history to be able to work with you in reaching your health and wellness goals.

115 North Main Street, Montgomery, Illinois 60538
Phone 630.801.8773 ● Fax 630.264.6734

Medical Questionnaire

Allergies

Medication/Supplement/Food/Environment:	Reaction:	DOCTOR NOTES:

Medications

Current Medications and Supplements: *Please attach a separate page if more space is needed.*

Medication	Dose	Frequency	Start Date (month / year)	Reason for Use

Tried Medications

Medications tried and did not work OR medications tried and had a reaction to:

Medication	Dose	Frequency	Start Date (month / year)	Reason for Discontinued Use

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, Aspirin, etc.)? ☐ Yes ☐ No
Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No
Have you had prolonged or regular use of acid blockers (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No
Do you use frequent antibiotics more than 3 times each year? ☐ Yes ☐ No
Do you use long-term antibiotics? ☐ Yes ☐ No
Have you used steroids in the past (Prednisone, nasal allergy inhalers, etc.) ☐ Yes ☐ No
Do you use oral contraceptives? ☐ Yes ☐ No

Complaints/Concerns

DOCTOR NOTES:

What do you hope to achieve in your visit with us?

If you had a magic wand and could erase three problems, what would they be?

1.

2.

3.

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel worse?

What makes you feel better?

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	**Prior Treatment/Approach**	Excellent	Good	Fair
Example: Post Nasal Drip		X		*Elimination Diet*	X		

Symptom Review

Please check all current symptoms occurring or present within the past 6 months

GENERAL:
☐ Cold intolerance
☐ Low body temperature
☐ Low blood pressure
☐ Daytime sleepiness
☐ Difficulty falling asleep
☐ Early waking
☐ Fatigue
☐ Fever
☐ Flushing
☐ Heat intolerance
☐ High blood pressure
☐ Night walking
☐ Nightmares
☐ No dream recall

HEAD, EYES & EARS:
☐ Conjunctivitis
☐ Distorted sense of smell
☐ Distorted taste
☐ Ear fullness
☐ Ear pain
☐ Ear ringing/buzzing
☐ Lid margin redness
☐ Eye crusting
☐ Eye pain
☐ Hearing loss
☐ Hearing problems
☐ Headache
☐ Migraine
☐ Sensitivity to loud noises
☐ Vision problems
☐ Macular degeneration
☐ Vitreous detachment
☐ Retinal detachment

EATING:
☐ Binge eating
☐ Bulimia
☐ Can't gain weight
☐ Can't lose weight
☐ Can't maintain healthy weight
☐ Frequent dieting
☐ Poor appetite
☐ Salt cravings
☐ Carbohydrate craving (bread/pasta)
☐ Sweet craving
(candy/cookies/cakes)
☐ Chocolate cravings
☐ Caffeine dependent

MOOD/NERVES:
☐ Agoraphobia
☐ Anxiety
☐ Auditory hallucinations
☐ Black-out
☐ Depression
☐ Difficulty concentrating
☐ Difficulty with balance
☐ Difficulty with judgment
☐ Difficulty with memory
☐ Difficulty with speech
☐ Difficulty with thinking
☐ Dizziness/spinning
☐ Fainting
☐ Fearfulness
☐ Irritability
☐ Light –headedness
☐ Numbness
☐ Other phobias
☐ Panic attacks
☐ Paranoia
☐ Seizures
☐ Suicidal thoughts
☐ Tingling
☐ Tremor/trembling
☐ Visual hallucinations

MUSCULOSKELETAL:
☐ Back muscle spasms
☐ Calf cramps
☐ Chest tightness
☐ Foot cramps
☐ Joint deformity
☐ Joint pain
☐ Joint redness
☐ Joint stiffness
☐ Muscle pain
☐ Muscle spasms
☐ Muscle stiffness
☐ Muscle twitch around eyes
☐ Muscle twitch in arms/legs
☐ Muscle weakness
☐ Cold hands and feet
☐ Neck muscle spasm
☐ Tendonitis
☐ Tension headache
☐ TMJ problems

DIGESTION:
☐ Anal spasms
☐ Bad teeth
☐ Bleeding gums
☐ Bloating of lower abdomen
☐ Bloating of whole abdomen
☐ Bloating after meals
☐ Blood in stool
☐ Burping
☐ Canker sores
☐ Cold sores
☐ Constipation
☐ Cracking at corner of lips
☐ Cramps
☐ Dentures with poor chewing
☐ Diarrhea
☐ Alternating diarrhea and constipation
☐ Difficulty swallowing
☐ Dry mouth
☐ Excess flatulence/gas
☐ Fissures
☐ Foods "repeat" (reflux)
☐ Gas
☐ Heartburn
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Upper abdominal pain
☐ Vomiting
☐ Intolerance to lactose
☐ Intolerance to all dairy products
☐ Intolerance to wheat
☐ Intolerance to gluten (wheat, rye, barley)
☐ Intolerance to corn
☐ Intolerance to eggs
☐ Intolerance to fatty foods
☐ Intolerance to yeast
☐ Liver disease / Jaundice (yellow eyes / skin)
☐ Abnormal liver function tests
☐ Lower abdomen pain
☐ Mucus in stool
☐ Periodontal Disease
☐ Sore tongue
☐ Strong stool odor
☐ Undigested food in stool

Symptom Review Continued

Please check all current symptoms occurring or present within the past 6 months

SKIN PROBLEMS:
❒ Acne on back
❒ Acne on chest
❒ Acne on face
❒ Acne on shoulders
❒ Athlete's foot
❒ Bumps on back of upper arms
❒ Cellulite
❒ Dark circles under eyes
❒ Ears get red
❒ Easy bruising
❒ Lack of sweating
❒ Eczema
❒ Hives
❒ Jock itch
❒ Lackluster skin
❒ Moles with color/size change
❒ Oily skin
❒ Pale skin
❒ Patchy dullness
❒ Rash
❒ Red face
❒ Sensitive to bites
❒ Sensitive to poison ivy/oak
❒ Shingles
❒ Skin darkening
❒ Strong body odor
❒ Hair loss
❒ Vitiligo

RESPIRATORY:
❒ Bad breath
❒ Bad odor in nose
❒ Dry cough
❒ Productive cough
❒ Hoarseness
❒ Sore throat
❒ Hay fever in spring
❒ Hay fever in summer
❒ Hay fever in fall
❒ Hay fever in season changes
❒ Nasal stuffiness
❒ Nose bleeds
❒ Post nasal drip
❒ Sinus fullness
❒ Sinus infection
❒ Snoring
❒ Wheezing
❒ Winter stuffiness

LYMPH NODES:
❒ Enlarged neck
❒ Tender neck
❒ Other enlarged/tender body parts
❒ Lymph nodes

ITCHING SKIN:
❒ Skin in general
❒ Anus
❒ Arms
❒ Ear canals
❒ Eyes
❒ Feet
❒ Hands
❒ Legs
❒ Nipples
❒ Nose
❒ Penis
❒ Roof of mouth
❒ Scalp
❒ Throat

DRYNESS OF SKIN:
❒ Eyes
❒ Feet
❒ Cracking skin on feet
❒ Peeling skin on feet
❒ Hair
❒ Unmanageable hair
❒ Hands
❒ Cracking skin on hands
❒ Peeling skin on hands
❒ Mouth/throat
❒ Scalp
❒ Dandruff
❒ Skin in general

NAILS:
❒ Bitten
❒ Brittle
❒ Curve up
❒ Frayed
❒ Fingernail fungus
❒ Toenail fungus
❒ Pitting
❒ Ragged cuticles
❒ Ridges
❒ Soft nails
❒ Thickening of fingernails
❒ Thickening of toenails
❒ White spots/lines

CARDIOVASCULAR:
❒ Angina/chest pain
❒ Breathlessness
❒ Heart murmur
❒ Irregular pulse
❒ Palpitations
❒ Phlebitis
❒ Swollen ankles/feet
❒ Varicose veins

URINARY:
❒ Bed wetting
❒ Hesitancy (trouble getting started)
❒ Infection
❒ Kidney Disease
❒ Leaking/incontinence
❒ Pain/burning
❒ Prostate infection
❒ Urgency

MALE REPRODUCTIVE:
❒ Discharge from penis
❒ Ejaculation problem
❒ Genital pain
❒ Impotence
❒ Prostate or urinary infection
❒ Lumps in testicles
❒ Poor libido (sex drive)

FEMALE REPRODUCTIVE:
❒ Breast cysts
❒ Breast lumps
❒ Breast tenderness
❒ Ovarian cyst
❒ Poor libido (sex drive)
❒ Vaginal discharge
❒ Vaginal odor
❒ Vaginal itch
❒ Vaginal pain with sex

Premenstrual:
- ❒ Bloating breast tenderness
- ❒ Carbohydrate cravings
- ❒ Chocolate cravings
- ❒ Constipation
- ❒ Decreased sleep
- ❒ Diarrhea
- ❒ Fatigue
- ❒ Increased sleep
- ❒ Irritability

Menstrual:
- ❒ Cramps
- ❒ Heavy periods
- ❒ Irregular periods
- ❒ No periods
- ❒ Scanty periods
- ❒ Spotting between periods

synergy health care

Genera om Review Form

Please check the appropriate box that most closely describes the amount of pain you experience, even occasionally, in various areas of your body.

Area of Body	Most Severe Pain Imaginable	Severe Pain	Moderately Severe Pain	Moderate Pain	Minimal to Moderate Pain	Minimal Pain	Minimal to No Pain	No Pain
Head								
Neck								
Shoulders								
Elbows								
Wrists/Hands								
Upper Back								
Low Back/Hips								
Knees								
Ankles/Feet								

Please mark whether or not you have pain with the following activities:

Firm grip: ❒ Yes ❒ No
Carrying groceries: ❒ Yes ❒ No
Sitting: ❒ Yes ❒ No
Bending: ❒ Yes ❒ No
Repetitive arm movement: ❒ Yes ❒ No
Twisting: ❒ Yes ❒ No
Squatting: ❒ Yes ❒ No
Pushing/pulling: ❒ Yes ❒ No
Standing: ❒ Yes ❒ No
Walking: ❒ Yes ❒ No
❒ I do not have pain with any of these activities

Please mark if you experience any of the following:

❒ Leg buckling
❒ Ankle weakness
❒ Leg cramps
❒ Restless legs
❒ Off balance feelings
❒ Concentration problems
❒ Problems sleeping
❒ Irritable bowel
❒ I do not experience any of these symptoms

Pain Map

Please indicate on the map your levels of pain.

(0 = no pain, 10 = worst pain imaginable)

Front **Back**

MEDICAL HISTORY

Please check all current or past diseases/diagnosis/conditions.

GASTROINTESTINAL

Past *Ongoing*

- ☐ ☐ Irritable bowel syndrome ________________
- ☐ ☐ Inflammatory bowel disease ____________________
- ☐ ☐ Crohn's ______________________________________
- ☐ ☐ Ulcerative colitis ______________________________
- ☐ ☐ Gastritis of Peptic Ulcer Disease __________________
- ☐ ☐ GERD (reflux) ________________________________
- ☐ ☐ Celiac Disease ________________________________
- ☐ ☐ Other ______________________________

CARDIOVASCULAR

Past *Ongoing*

- ☐ ☐ Heart attack __________________________________
- ☐ ☐ Other heart disease ____________________________
- ☐ ☐ Stroke ______________________________________
- ☐ ☐ Elevated cholesterol ___________________________
- ☐ ☐ Arrhythmia (irregular heart beat) _________________
- ☐ ☐ Hypertension (high blood pressure) ________
- ☐ ☐ Rheumatic Fever ______________________________
- ☐ ☐ Mitral valve prolapsed _________________________
- ☐ ☐ Other ______________________________

METABOLIC

Past *Ongoing*

- ☐ ☐ Type 1 diabetes _______________________
- ☐ ☐ Type 2 diabetes _______________________
- ☐ ☐ Hypoglycemia ________________________________
- ☐ ☐ Metabolic syndrome (insulin-resistance/pre-diabetes) ____
- ☐ ☐ Hypothyroidism (low thyroid) ____________________
- ☐ ☐ Hyperthyroidism (overactive thyroid) ______________
- ☐ ☐ Endocrine problems ____________________________
- ☐ ☐ Polycystic ovarian syndrome (PCOS) _______________
- ☐ ☐ Infertility ____________________________________
- ☐ ☐ Weight gain ___________________________________
- ☐ ☐ Weight loss ___________________________________
- ☐ ☐ Frequent weight fluctuations ____________________
- ☐ ☐ Bulimia _______________________________________
- ☐ ☐ Anorexia ______________________________________
- ☐ ☐ Binge eating disorder __________________________
- ☐ ☐ Eating disorder (non-specific) ___________________
- ☐ ☐ Other ______________________________

CANCER

Past *Ongoing*

- ☐ ☐ Lung ______________________________
- ☐ ☐ Breast ______________________________________
- ☐ ☐ Colon ______________________________
- ☐ ☐ Ovarian _____________________________________
- ☐ ☐ Prostate ____________________________________
- ☐ ☐ Skin ____
- ☐ ☐ Other ______________________________

GENITOURINARY

Past *Ongoing*

- ☐ ☐ Kidney stones ________________________________
- ☐ ☐ Gout ______________________________
- ☐ ☐ Interstitial cystitis ____________________________
- ☐ ☐ Frequent urinary tract infections __________________
- ☐ ☐ Frequent yeast infections _______________
- ☐ ☐ Erectile/sexual dysfunction ______________________
- ☐ ☐ Other ______________________________

MUSCULOSKELETAL

Past *Ongoing*

- ☐ ☐ Osteoarthritis ________________________________
- ☐ ☐ Fibromyalgia _________________________________
- ☐ ☐ Chronic pain _________________________________
- ☐ ☐ Other ______________________________

INFLAMMATORY / AUTOIMMUNE

Past *Ongoing*

- ☐ ☐ Chronic Fatigue Syndrome ______________________
- ☐ ☐ Autoimmune disease ___________________________
- ☐ ☐ Rheumatoid Arthritis ___________________________
- ☐ ☐ Lupus SLE ____________________________________
- ☐ ☐ Immune Deficiency Disease _____________________
- ☐ ☐ Herpes—genital ______________________________
- ☐ ☐ Severe Infectious Disease _______________
- ☐ ☐ Poor immune function (frequent infections) _________ ____
- ☐ ☐ Food allergies ________________________________
- ☐ ☐ Environmental allergies ________________________
- ☐ ☐ Multiple chemical sensitivities ___________________ ____
- ☐ ☐ Latex allergy _________________________________
- ☐ ☐ Other ______________________________

RESPIRATORY

Past *Ongoing*

- ☐ ☐ Asthma ______________________________________
- ☐ ☐ Chronic sinusitis ______________________________
- ☐ ☐ Bronchitis ____________________________________
- ☐ ☐ Emphysema ___________________________________
- ☐ ☐ Pneumonia ___________________________________
- ☐ ☐ Tuberculosis __________________________________
- ☐ ☐ Sleep apnea __________________________________
- ☐ ☐ Other ______________________________

SKIN

Past *Ongoing*

- ☐ ☐ Eczema ______________________________________
- ☐ ☐ Psoriasis _____________________________________
- ☐ ☐ Acne ______________________________
- ☐ ☐ Melanoma ____________________________________
- ☐ ☐ Skin cancer __________________________________
- ☐ ☐ Other ______________________________

MEDICAL HISTORY CONTINUED

NEUROLOGICAL

Past Ongoing

- ☐ ☐ Depression ______
- ☐ ☐ Anxiety ______
- ☐ ☐ Bipolar disorder ______
- ☐ ☐ Schizophrenia ______
- ☐ ☐ Headaches ______
- ☐ ☐ Migraines ______
- ☐ ☐ ADD/ADHD ______
- ☐ ☐ Autism ______
- ☐ ☐ Mild cognitive impairment ______
- ☐ ☐ Memory problems ______
- ☐ ☐ Parkinson's Disease ______
- ☐ ☐ ALS ______
- ☐ ☐ Seizures ______
- ☐ ☐ Other ______

PREVENTATIVE TESTS

Check box if yes and fill in date of last test:

- ☐ Full physical exam ______
- ☐ Bone density ______
- ☐ Colonoscopy ______
- ☐ Cardiac Stress Test ______
- ☐ EBT Heart Scan ______
- ☐ EKG ______
- ☐ Hemoccult Test (stool test for blood) ______
- ☐ MRI ______
- ☐ CT scan ______
- ☐ Upper endoscopy ______
- ☐ Upper GI series ______
- ☐ Ultrasound ______

INJURIES

Check box if yes and fill in date of injury:

- ☐ Back injury ______
- ☐ Neck injury ______
- ☐ Head injury ______
- ☐ Broken bones ______
- ☐ Other ______

______

SURGERIES

Check box if yes and fill in date of surgery:

- ☐ Appendectomy ______
- ☐ Hysterectomy + / - Ovaries ______
- ☐ Gall bladder ______
- ☐ Hernia ______
- ☐ Tonsillectomy ______
- ☐ Dental surgery ______
- ☐ Joint replacement (knee / hip) ______
- ☐ Heart surgery (bypass valve) ______
- ☐ Angioplasty / stent ______
- ☐ Pacemaker ______
- ☐ Other ______

______

- ☐ None ______

BLOOD TYPE

☐ A ☐ B ☐ AB

☐ 0 ☐ Rh+ ☐ Unknown

HOSPITALIZATIONS

☐ None

Date	Reason

TRAUMA HISTORY

Please include minor/minimal traumas.

MOTOR VEHICLE ACCIDENTS:

Date/Year	Driver or Passenger	Damage to Vehicle	Your Injuries

FALLS AND BLUNT TRAUMA: *(Slip and fall, sports/work injuries, etc.)*

Date/Year	Type of Trauma	Your Injuries

GYNECOLOGIC HISTORY *(for women only)*

OSTETRIC HISTORY

If yes, check box and provide number of times

☐ Pregnancies ____________________ ☐ Caesarean _____________________ ☐ Vaginal deliveries ________________________

☐ Miscarriage ____________________ ☐ Abortion ______________________ ☐ Living children ___________________________

☐ Post partum depression ☐ Toxemia ☐ Gestational diabetes ☐ Baby over 8 pounds

☐ Breast feeding How long? _______________

MENSTRUAL HISTORY

Age at first period _________________ Menses frequency _________________ Length __________________________

Has your period ever skipped? ☐ Yes ☐ No For how long? ____________________

Pain? ☐ Yes ☐ No

Clotting? ☐ Yes ☐ No

Last menstrual period: _____________

Use of hormonal contraception? ☐ Yes ☐ No
If yes, do you use: ☐ Birth control pills ☐ Patch ☐ Nuva Ring ☐ IUD (Mirena)

Use of non-hormonal contraception? ☐ Yes ☐ No
If yes, do you use: ☐ Condom ☐ Diaphragm ☐ IUD (Paragard) ☐ Tubal ligation ☐ Partner vasectomy

WOMEN'S DISORDERS / HORMONAL IMBALANCES

☐ Fibrocystic breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility

☐ Painful periods ☐ Heavy periods ☐ PMS ☐ PMDD

Last mammogram: ________________ Breast biopsy date: ________________

Last PAP test: _____________________ ☐ Normal ☐ Abnormal

Date of last bone density: ___________________ Results: ☐ High ☐ Low ☐ Within normal range

Are you in menopause? ☐ Yes ☐ No Age at menopause? ________________

☐ Hot flashes ☐ Mood swings ☐ Concentration/memory problems ☐ Vaginal dryness ☐ Decreased libido

☐ Heavy bleeding ☐ Joint pains ☐ Headaches ☐ Weight gain ☐Loss of control of urine ☐ Palpitations

☐ Use of hormone replacement therapy. How long? _____________________

MEN'S HISTORY *(for men only)*

Have you had a PSA done? ☐ Yes ☐ No

PSA level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ 10+

☐ Prostate enlargement ☐ Prostate infection ☐ Change in libido ☐ Impotence

☐ Difficulty obtaining an erection ☐ Difficulty maintaining an erection

☐ Nocturia (urination at night) How many times at night? __________________

☐ Urgency/hesitancy/change in urinary stream ☐ Loss of control of urine

GI HISTORY

Foreign travel? ☐ Yes ☐ No Where? ______________________________

Wilderness camping? ☐ Yes ☐ No Where? ______________________________

Severe gastroenteritis? ☐ Yes ☐ No

Severe diarrhea? ☐ Yes ☐ No

Do you feel like you digest food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

PATIENT BIRTH HISTORY

☐ Term ☐ Premature

Pregnancy complications? ☐ Yes ☐ No What? ______________________________

Birth complications? ☐ Yes ☐ No What? ______________________________

☐ Breast fed How long? ____________________ ☐ Bottle-fed

Age at introduction of solid foods: ____________________

Age at introduction of dairy: ____________________

Age at introduction of wheat: ____________________

Did you eat a lot of candy/sugars as a child? ☐ Yes ☐ No

DENTAL HISTORY/SURGERY

☐ Silver mercury fillings How many? ____________________

☐ Gold fillings How many? ____________________

☐ Root canals How many? ____________________

☐ Implants How many? ____________________

☐ Tooth pain

☐ Bleeding gums

☐ Gingivitis

☐ Problems with chewing

Do you floss regularly? ☐ Yes ☐ No

OTHER

____

____

____

____

____

____

____

FAMILY HISTORY

Check family members that apply

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt(s)	Uncle(s)	Other
Age (if alive)												
Age at death (if deceased)												
Cancers												
Colon cancer												
Breast / Ovarian cancer												
Heart disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory arthritis												
Inflammatory bowel disease												
Multiple sclerosis												
Auto Immune Diseases												
Irritable bowel syndrome												
Celiac disease												
Asthma												
Eczema / Psoriasis												
Food allergies/sensitivities/intolerances												
Environmental allergies/sensitivities/intolerances												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic disorders												
Substance abuse												
Psychiatric disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar disorder												