



Medical History and Symptomatic Questionnaire

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➤ Demographics

Date Completed: ____ / ____ / ____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State or Prov _____ Zip: _____

Gender: M or F

Date of Birth: ____ / ____ / ____

➤ Communication Methods

Phone (Preferred): ____ - ____ - _____ Type of Phone: Home / Mobile / Business

Approved for confidential/personal information: Approved / Not Approved

Phone (Secondary): ____ - ____ - _____ Type of Phone: Home / Mobile / Business

Approved for confidential/personal information: Approved / Not Approved

E-Mail Address: _____ @ _____

Approved for confidential/personal information: Approved / Not Approved

➤ Emergency Contact:

Name: _____ Telephone: ____ - ____ - _____

Relationship: _____

➤ Physician Information

No Primary Care Physician

No Specialist

Primary Care Physician

Specialist Physician

Name: _____

Name: _____

Address: _____

Address: _____

Phone: ____ - ____ - _____

Phone: ____ - ____ - _____

➤ **Chief Goal:**

Briefly explain why it is you came to see the physician:

➤ **Energy Level**

Please rank the follow from 0 = zero energy to 10 = very energetic

What time do you awaken?	Level 1 - 10 ____	Did you eat? ____
1 hour after awaking	Level 1 - 10 ____	Did you eat? ____
10 AM (or 3 hrs after awake)	Level 1 - 10 ____	Did you eat? ____
Noon (or 5 hrs after awake)	Level 1 - 10 ____	Did you eat? ____
3-5 PM (or 7-9 hrs after awake)	Level 1 - 10 ____	Did you eat? ____
Dinner	Level 1 - 10 ____	Did you eat? ____
8 - 9 PM	Level 1 - 10 ____	Did you eat? ____
11 PM	Level 1 - 10 ____	Did you eat? ____

➤ **Allergies:**

No known allergies to medications

Antibiotics: Penicillin Sulfa Other antibiotic.(Please list):

Prescription Medication: Morphine Dye allergies Codeine Aspirin

Environmental Allergies: Seasonal Pet allergies Food allergies

Food Allergies: Peanuts Shellfish Soy

Any Mercury Fillings? Yes No

Any other allergy?: (please list):

Please describe the reaction to the allergen listed above. Was it life-threatening?

Describe the extent to which you are exposed to chemicals.

➤ **G.I. Health:**

	Yes	No
Do you experience fatigue and “foggy thinking”?	<input type="radio"/>	<input type="radio"/>
Do you crave sugar; have a bloated abdomen or abdominal pain?	<input type="radio"/>	<input type="radio"/>
Do you have recurrent yeast, vaginal, prostate, or urinary tract infections or rashes?	<input type="radio"/>	<input type="radio"/>
Do you have a white coating on your tongue or inside your mouth?	<input type="radio"/>	<input type="radio"/>
Do you have chronic sinus problems?	<input type="radio"/>	<input type="radio"/>
Do you have itchy rashes on your skin?	<input type="radio"/>	<input type="radio"/>
Do you feel 20 to 30 years older than you really are?	<input type="radio"/>	<input type="radio"/>
Does your long struggle for health cause you depression?	<input type="radio"/>	<input type="radio"/>
Have you been sent home by doctors who say “nothing is wrong with you” when something is obviously wrong?	<input type="radio"/>	<input type="radio"/>
Have you taken repeated or prolonged courses of antibacterial drugs?	<input type="radio"/>	<input type="radio"/>
Are you bothered by hormone disturbances, including PMS, menstrual irregularities, sexual dysfunction, sugar cravings, low body temperature or fatigue?	<input type="radio"/>	<input type="radio"/>
Are you unusually sensitive to tobacco smoke, perfumes, colognes and other chemical odors?	<input type="radio"/>	<input type="radio"/>
Are you bothered by memory or concentration problems? Do you sometimes feel spaced out?	<input type="radio"/>	<input type="radio"/>
Have you taken prolonged courses of prednisone or other steroids for more than 3 years?	<input type="radio"/>	<input type="radio"/>
Do some foods disagree with you or trigger your symptoms?	<input type="radio"/>	<input type="radio"/>
Do you suffer with constipation, diarrhea, bloating, or abdominal pain?	<input type="radio"/>	<input type="radio"/>
Does your skin itch, tingle or burn; or is it unusually dry; or are you bothered by rashes?	<input type="radio"/>	<input type="radio"/>

➤ **Sleep Pattern**

- What time do you go to bed? _____
- How long does it take to fall asleep? _____
- How many hours do you sleep before you awaken for any reason? _____
- Are you able to get back to sleep? _____
- Do you awaken in the morning feeling tired? True / False
- Do you snore loudly? True / False
- Do you often wake up with a headache? True / False

➤ **Past Medical History**

Please check any medical conditions or health problems that you currently have or have had in the past?

<u>Condition</u>	<u>Now</u>	<u>Past</u>		<u>Condition</u>	<u>Now</u>	<u>Past</u>	
Seizures Disorder	<input type="radio"/>	<input type="radio"/>		Heart Disease	<input type="radio"/>	<input type="radio"/>	
Seasonal allergies	<input type="radio"/>	<input type="radio"/>		Chest Pain	<input type="radio"/>	<input type="radio"/>	
Psychiatric or Emotional Illness	<input type="radio"/>	<input type="radio"/>		Irregular Heart Beat	<input type="radio"/>	<input type="radio"/>	
Depression	<input type="radio"/>	<input type="radio"/>		High Blood Pressure	<input type="radio"/>	<input type="radio"/>	
Anxiety or excessive stress	<input type="radio"/>	<input type="radio"/>		Blood Clotting problems	<input type="radio"/>	<input type="radio"/>	
Asthma	<input type="radio"/>	<input type="radio"/>		Bleeding disorder	<input type="radio"/>	<input type="radio"/>	
Chronic bronchitis	<input type="radio"/>	<input type="radio"/>		Stroke/vascular disease	<input type="radio"/>	<input type="radio"/>	
Lung or breathing problems	<input type="radio"/>	<input type="radio"/>		Constipation/diarrhea	<input type="radio"/>	<input type="radio"/>	
Chronic Indigestion	<input type="radio"/>	<input type="radio"/>		Hepatitis/Liver disease	<input type="radio"/>	<input type="radio"/>	
Stomach Ulcers	<input type="radio"/>	<input type="radio"/>		Kidney disease	<input type="radio"/>	<input type="radio"/>	
Skin problems/dermatitis	<input type="radio"/>	<input type="radio"/>		Kidney stones	<input type="radio"/>	<input type="radio"/>	
Herniated Disc	<input type="radio"/>	<input type="radio"/>		Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	
Carpal Tunnel Syndrome	<input type="radio"/>	<input type="radio"/>		Artificial joint/implants	<input type="radio"/>	<input type="radio"/>	
Fibromyalgia	<input type="radio"/>	<input type="radio"/>		Cancer	<input type="radio"/>	<input type="radio"/>	
Diabetes	<input type="radio"/>	<input type="radio"/>		Psoriasis or eczema	<input type="radio"/>	<input type="radio"/>	
Thyroid disease	<input type="radio"/>	<input type="radio"/>		Tuberculosis	<input type="radio"/>	<input type="radio"/>	
Osteoporosis/Osteopenia	<input type="radio"/>	<input type="radio"/>		Glaucoma	<input type="radio"/>	<input type="radio"/>	
Osteoarthritis	<input type="radio"/>	<input type="radio"/>					

➤ **Surgeries**

Please list all surgeries that you have had since birth. Include the year.

Surgery	Year

➤ **Over-the-counter (OTC) Products**

Please check all products that you use regularly. Check all that apply

Pain Reliever

- Aspirin
- Acetaminophen (example: Tylenol®)
- Ibuprofen (example: Motrin IB®)
- Ketoprofen (example: Orudis KT®)
- Naproxen (example: Aleve®)

Cough and Cold

- Cough + cold reliever (ex: Triaminic)
- Cough suppressant (ex: Robitussin DM®)
- Antihistamine product (ex. ChlorTrimeton)
- Decongestant product (ex.: Sudafed)
- Other (please list)

Non-Prescription Sleep Aids

- Non-prescription Sleep aids (example: Unisom®, Sominex®, and Nytol®)
- Non-prescription Diet aids/weight loss products (example: Dexatril®)

Stomach Problems

- Anti-diarrhea Medication (examples: Imodium®, Pepto Bismol®, and Kaopectate®)
- Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)
- Antacids (examples: Maalox®, Mylanta®)
- Acid blockers (examples: Tagamet HB®, Pepcid C®, and Zantac 75®)

➤ **Prescription Medications - Hormones**

Hormones previously taken. (This includes birth control, female or male hormones, thyroid)

	Hormone Name	Strength	How often per day?	Year Started	Year Stopped
1					
2					
3					
4					
5					

➤ **Prescription Medications – Prescribed by a Physician**

This includes any medication or therapy prescribed by a physician.

	Name of Medication	Strength: units in mgs, gms, IU, mcg	At what times do you take this medication?	Year Started.	Are you currently taking this medication?
1					
2					
3					
4					
5					

➤ **Nutritional/Natural Supplements:**

This includes any pill, substance, or supplement that you bought at a store or pharmacy without a doctor's prescription.

	Supplement	Manufacturer	Major Ingredients	Strength of Ingredients	For what reason do you take this supplement
1					
2					
3					
4					
5					
6					
7					

Social History

- Do you have a lot of stress in your life? Yes No
Do you use tobacco? Yes No
Do you use alcohol? Yes No
Do you meditate daily? Yes No
Do you drink coffee or products containing caffeine? Yes No
Are you employed? Yes No
If yes, what is your occupation? _____
Is the job stressful? Yes No
Do you take breaks from working? Yes No
Is your job physically demanding? Yes No
Are you retired? Yes No
If yes, is retirement stressful? Yes No
Sexual Orientation (you may decline to answer)
 Heterosexual (Straight) Homosexual (Gay)
Marital Status:
 Single Divorced Married/Partnered
 Partner/Significant Others Name _____
Do you have any children? Yes No
If so, kindly list their names and their ages: _____
Do they live with you? Yes No

Dietary Habits

- No special diet habits Avoids red meat Minimizes fat
 Minimizes Carbohydrates Vegetarian
 Emphasize fruits, grains and vegetables I try to eat a healthy diet
 I do not eat dairy / cheese I commonly eat at fat-food restaurants
I commonly consume: Coffee Regular soft drinks Diet soda
 Candy/chocolate Chips / crackers
_____ Oz. of water per day

Family History

Do you have a family member (mother, father, grandparents or sibling) with any of the following? You may use the abbreviations, and only these relations are of significance: M = mother, F = father, S = sister, B = brother, MGM = maternal grandmother, MGF = maternal grandfather, PGM = paternal grandmother, PGF = paternal grandfather.

- | | |
|--|---------------------------|
| <input type="checkbox"/> Breast Cancer | If so, relationship _____ |
| <input type="checkbox"/> Prostate Cancer | If so, relationship _____ |
| <input type="checkbox"/> Uterine Cancer | If so, relationship _____ |
| <input type="checkbox"/> Ovarian Cancer | If so, relationship _____ |
| <input type="checkbox"/> Colon Cancer | If so, relationship _____ |
| <input type="checkbox"/> Fibrocystic breast | If so, relationship _____ |
| <input type="checkbox"/> Heart Disease or stroke | If so, relationship _____ |
| <input type="checkbox"/> High Cholesterol | If so, relationship _____ |
| <input type="checkbox"/> Diabetes | If so, relationship _____ |
| <input type="checkbox"/> High Blood Pressure | If so, relationship _____ |
| <input type="checkbox"/> Osteoporosis/Osteopenia | If so, relationship _____ |
| <input type="checkbox"/> Alzheimer's disease | If so, relationship _____ |

Previous Tests

Have you had any of the following tests performed?

- | | | |
|------------------------------|------------------------------|-----------------------------|
| Mammography | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, list month/year: | | |
| If yes, what was the result? | | |
| PAP Smear | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, list month/year: | | |
| If yes, what was the result? | | |
| Uterine Ultrasound | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, list month/year: | | |
| If yes, what was the result? | | |
| Bone Density | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, list month/year: | | |
| If yes, what was the result? | | |
| Stress Test: (Treadmill) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, list month/year: | | |
| If yes, what was the result? | | |

Exercise History

- | | | |
|--|------------------------------|-----------------------------|
| Do you do exercises? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you do weight resistant exercises? (Lift weights) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you do aerobic exercises? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

SYMPTOMATIC QUESTIONNAIRE

PART 1: (Women and Men)

Please check all of the symptoms you are currently experiencing.

Adrenal Fatigue

- Fatigue, especially around 2 to 4pm
- Allergies are worse
- Craving for salt and sugar
- Chemical or other sensitivities that you never had before
- You wake up after 3 hours of being asleep then you are unable to go to sleep for a few hours, until the last portion of the night between before you wake up.
- After a stressful day, you feel worn out
- When you miss a meal, you get irritable or weak
- Difficult keeping your focus and concentration
- When you get a cold, it seems to last a long time
- In the past you were an “adrenaline junkie” (liked daring thrills) but now you avoid those situations.
- Age spots appearing on arms and face

Adrenal Stress

- At night, you lie awake unable to fall asleep, but your body is tired
- You are stressed, but you are able to handle it.
- You are an “adrenaline junkie”, you like daring thrills
- Hair loss all over your head.
- Weight gain, especially in front of stomach, love handles and face
- Anxiety
- Craving for sweets
- You currently work best under pressure
- After something eventful happens, you feel energized

Thyroid Deficiency

- Fatigue constant through the day
- Low stamina
- Cold hands and feet
- Intolerance to cold (you do not like winter because of the coldness)
- Weight gain
- Hair loss all over your head
- Swollen, puffy eyes
- Brittle nails

PART 1: (Women and Men) cont.

Thyroid Excess

- Nervousness
- Irritable or angry
- Hand tremors
- Insomnia
- Palpitations (skipped heartbeats)
- Weight loss even though you are not dieting
- Diarrhea
- Warm hands and feet

GH Deficiency

- General muscle loss
- "Pot belly"
- More facial wrinkles
- Reduced exercise capacity
- Loss of concentration
- Loss of self confidence/self esteem
- Decreased in quality of sleep
- Sagging cheeks
- Thinning lips

PART 2: (Men Only)

- Very Stressed
- Inability to cope
- Backache
- Joint Aches
- History of prostate disease
- Urinary frequency
- Fatigue
- Depression
- Decreased libido
- Decreased muscle mass
- Erectile dysfunction

PART 3: (Women Only) cont.

Progesterone Deficient

- Snoring (and you did not before)
- Urinary leakage (urine does not stop or comes out at inappropriate times)
- Aches in joints
- Varicose veins
- Weird dreams
- Lower back pain
- Your periods are Irregular or have stopped
- Headaches before or during your periods

Androgen Deficiency

- Good energy when you wake up, and all through the day until just around 6-7pm when you are ready to take a nap
- Trouble remembering directions
- Trouble remembering number
- Difficult hold back tears/emotions
- Decreased libido
- Muscle weakness
- Diminished feeling of well being

Estrogen Loss

- Hot flashes
- Night sweats
- Vaginal dryness
- Dry skin, eyes, or mouth
- Breast have become smaller, droopy
- Foggy thinking
- Forget names of people or objects
- Painful intercourse
- Hair loss on the crown of head

Androgen Excess

- Acne
- Hair loss in the front
- Hair on face and nipple area
- Deepening of voice
- Clitoral enlargement
- Irritability/moodiness
- Insomnia

PART 3: (Women Only) cont.

Women on hormone therapy (natural or synthetic)

- Progesterone Excess
- Feeling sedated
- Heartburn
- Gastrointestinal bloating
- Depression with loss of interest
- Frequent yeast Infections

Yeast

- Sugar cravings
- Muscle aches and pains
- Sick all over
- Chemical sensitivities
- Spacey