Dr Anthony de Pontes

Integrative Natural Medicine Solutions

Registered Homeopath, Acupuncturist and Functional Medicine Practitioner

# HEALTH HISTORY FORMS

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**PLEASE SEND THIS FORM 2 DAYS IN ADVANCE OF YOUR APPOINTMENT**

# BRIEF HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Please include any lab tests you have had done in the case history for consideration.

Date:_____

First Name:_____ Middle:_____Last:_____

Address _____ City _____ State _____ Zip Code_____

Home Phone (____) _____-_____ Work (____) _____-_____ Cell (____) ____-_____

Email _____

Age _____ Date of Birth ____/____/_____ Place of birth_____ Gender: Female__Male___

City or town & country, if not US

Referred by:_____

Marital Status:

Single____ Married____ Divorced____ Widowed____ Long Term Partnership____

Emergency Contact: _____

Relationship Name Phone

_____

Address

Occupation _____ Hours per week _____ Retired _____

Nature of Business_____

Genetic Background/ Race: Please check appropriate box(es):

| | | | |
|---|---|---|---|
| ❑ Black | ❑ Indian | ❑ Mediterranean | ❑ Asian |
| ❑ Coloured | ❑ Caucasian (white) | ❑ Northern European | ❑ Other |

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## CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

| Problem | Date of Onset | Severity/Frequency | Treatment Approach | Success |
|---|---|---|---|---|
| **Example:** Headaches | May 2006 | 2 times per week | Acupuncture/Aspirin | Mild improvement |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**1. Chief Complaint Today.**

When did it appear?

_____

Any possible cause (accident, worry or stressful event, infection). Please describe anything that you feel is associated with the current symptoms that is unusual, rare or peculiar which you wish to add.

_____

_____

**MODALITIES** (time of occurrence, temperature, position (side of the body affected), food, description of pain, extension of pain to other parts of body)

_____

_____

What diagnosis or explanation(s), if any, have been given to you for these concerns?

_____

_____

_____

When was the last time that you felt well?_____

What seems to trigger your symptoms? (weather, time of day, food, body position)_____

_____

What seems to worsen your symptoms?_____

What seems to make you feel better?_____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?_____

_____

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## PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

| ILLNESSES | WHEN /ONSET (YEAR) | COMMENTS |
|---|---|---|
| Anemia | | |
| Arthritis | | |
| Asthma | | |
| Bronchitis | | |
| Cancer | | |
| Chicken Pox | | |
| Chronic Fatigue Syndrome | | |
| Crohn's Disease or Ulcerative Colitis | | |
| Diabetes | | |
| **ILLNESS** | **WHEN/ONSET** | **COMMENTS** |
| Emphysema | | |
| Epilepsy, convulsions, or seizures | | |
| Gallstones | | |
| German Measles | | |
| Gout | | |
| Heart Attack, Angina | | |
| Heart Failure | | |
| Hepatitis | | |
| Herpes Lesions/Shingles | | |
| High blood fats (cholesterol, triglycerides) | | |
| High blood pressure (hypertension) | | |
| Irritable bowel (or chronic diarrhea) | | |
| Kidney stones | | |
| Measles | | |
| Mononucleosis | | |
| Mumps | | |
| Pneumonia | | |
| Rheumatic Fever | | |
| Sinusitis | | |
| Sleep Apnea | | |
| Stroke | | |

| | | |
|---|---|---|
| Thyroid disease | | |
| Whooping Cough | | |
| Other (describe) | | |
| Other (describe) | | |
| **INJURIES** | **WHEN** | **COMMENTS** |
| Back injury | | |
| Broken bones or fractures (describe) | | |
| Head injury | | |
| Neck injury | | |
| Other (describe) | | |

| | | |
|---|---|---|
| | | |
| **SURGERIES** | **WHEN** | **COMMENTS** |
| Appendectomy | | |
| Dental Surgery | | |
| Gall Bladder | | |
| Hernia | | |
| Hysterectomy | | |
| Tonsillectomy | | |
| Gromits (Tubes in Ears) | | |
| Other (describe) | | |

## MEDICATIONS

| **How often have you taken antibiotics?** | **Less than 5 times** | **More than 5 times** | **Comments** |
|---|---|---|---|
| Infancy/Childhood | | | |
| Teen | | | |
| Adulthood | | | |

| **How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc.)** | **Less than 5 times** | **More than 5 times** | **Comments** |
|---|---|---|---|
| Infancy/Childhood | | | |
| Teen | | | |
| Adulthood | | | |

**List all medications. Include all over the counter non-prescription drugs.**

**PLEASE SEND THIS FORM 2 DAYS IN ADVANCE OF YOUR APPOINTMENT**

| Medication Name | Date started | Date stopped | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate the dosage.**

| Type | Date Started | Date Stopped | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are you allergic to any medication, vitamin, mineral or other nutritional supplement? Yes___ No ___

If yes, please list:_____

_____

## CHILDHOOD HISTORY

Please answer to the best of your knowledge.

| | Yes | No | Don't Know | Comment |
|---|---|---|---|---|
| Where you a full-term baby? | | | | |
| A premature birth? ('preemie') | | | | |
| Breast fed? | | | | |
| Bottle fed? | | | | |
| When pregnant with you, did your mother: | | | | |
| Smoke tobacco? | | | | |
| Use recreational drugs? | | | | |

| | | | | |
|---|---|---|---|---|
| Drink alcohol? | | | | |
| Use estrogen? | | | | |

## IMMUNIZATION HISTORY

| Please indicate if you have been vaccinated against any of the following diseases: | Yes | No | Don't Know | Comment |
|---|---|---|---|---|
| Smallpox | | | | |
| Tetanus | | | | |
| Diphtheria | | | | |
| Pertussis | | | | |
| Polio (oral) | | | | |
| Polio (injection) | | | | |
| Mumps | | | | |
| Measles | | | | |
| Rubella (German Measles) | | | | |
| Typhoid | | | | |
| Cholera | | | | |

To the best of your knowledge, do you know whether you had any reactions to your vaccinations (crying, abscess, ADHD, autism, repeated infections, if so which vaccine?

# FEMALE MEDICAL HISTORY

*(For women only)*

## OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies_____
- ❑ Caesarean _____
- ❑ Vaginal deliveries_____
- ❑ Miscarriage _____
- ❑ Abortion _____
- ❑ Living Children_____
- ❑ Post-partum depression___
- ❑ Toxemia _____
- ❑ Gestational diabetes_____

## GYNECOLOGICAL HISTORY

Age at first menses? _____ Frequency:_____ Length:_____

Painful: Yes_____ No_____ Clotting: Yes____ No____

**PLEASE SEND THIS FORM 2 DAYS IN ADVANCE OF YOUR APPOINTMENT**

Date of last menstrual period: ____/____/_____

Do you currently use contraception? Yes____ No____ If yes, please indicate which form:

Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)_____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long. (dates)_____

_____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes _____ No _____

Please advise of any other symptoms that you feel are significant._____

_____

_____

Are you menopausal? Yes_____ No_____ If yes, age of menopause_____

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?_____

❑ Estrogen ❑ Other ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera

a. Have you ever been sexually molested or abused? _____

   Is that event affecting you still today? _____

b. At what age did your period begin? _____

c. How frequently do your periods come? Days? _____

d. Please describe their duration, abundance, colour, and odour

   _____

   _____

   _____

e. Please describe any significant details that may be relevant.

   _____

   _____

   _____

f. Do you suffer pain during your period? When? type? Associated symptoms?

   _____

   _____

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g. Do you suffer with vaginal discharge (color, itchy, when it appears, what aggravates it, what improves it?

_____

_____

_____

h. How do you feel before, during and after your period?

_____

_____

i. What about your character, feeling or behavior before, during and after your period?

_____

_____

j. Do you ever feel a bearing down during menses, like everything wants to fall out from between your legs?

_____

_____

k. Do you suffer from breast tenderness or swelling? When? Symptoms associated with it?

_____

_____

l. Do you have any breast lumps?

_____

_____

m. Are you sexually active?

_____

n. Do you have pain on intercourse? (when, what position, character of the pain)

_____

_____

o. Do you enjoy sexual intercourse?

_____

_____

p. What is your sexual desire or appetite like? _____

q. Do you have 'intimate dryness' or pain on intercourse? _____

r. Do you struggle with hot flushes? If so, where do you feel the heat? And when?

_____

_____

## DIAGNOSTIC TESTING

Last PAP test: _____/_____/_____ Normal:_____Abnormal_____

Last Mammogram_____/_____/_____ Breast biopsy? Date: _____/_____/_____

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Date of last bone density_____/_____/_____ Results: High____ Low____ Within normal range____

## MEN ONLY

a. Do you suffer with pain on urination?

_____

b. Have you ever suffered with a sexually transmitted disease? Which one, how long ago?_____

_____

c. Do you have to get up at night to urinate? How many times?

_____

_____

d. Are you able to achieve suitable erections for intercourse?

_____

_____

e. How many days a week or month do you engage in sexual activities?

_____

_____

f. Do you suffer with urinary burning or discharge? Is it blood stained? Color?

_____

_____

g. Do you have a good libido or sex drive?

_____

_____

h. Do you wake up with an erection?

_____

_____

i. Do you struggle with back pain esp. after intercourse?

_____

_____

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## FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

| Check Family Members that Apply | Father | Mother | Brother(s) | Sister(s) | Children | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|---|---|---|---|---|---|---|---|---|---|
| Age (if still living) | | | | | | | | | |
| Age at death (if deceased) | | | | | | | | | |
| Heart Attack | | | | | | | | | |
| Stroke | | | | | | | | | |
| Uterine Cancer | | | | | | | | | |
| Colon Cancer | | | | | | | | | |
| Breast Cancer | | | | | | | | | |
| Ovarian Cancer | | | | | | | | | |
| Prostate Cancer | | | | | | | | | |
| Skin Cancer | | | | | | | | | |
| ADD/ADHD | | | | | | | | | |
| ALS or other Motor Neuron Diseases | | | | | | | | | |
| Alzheimer's | | | | | | | | | |
| Anemia | | | | | | | | | |
| Anxiety | | | | | | | | | |
| Arthritis | | | | | | | | | |
| Asthma | | | | | | | | | |
| Autism | | | | | | | | | |
| Autoimmune Diseases (such as Lupus) | | | | | | | | | |
| Bipolar Disease | | | | | | | | | |
| Bladder disease | | | | | | | | | |
| Blood clotting problems | | | | | | | | | |
| Celiac disease | | | | | | | | | |
| Dementia | | | | | | | | | |
| Depression | | | | | | | | | |
| Diabetes | | | | | | | | | |
| Eczema | | | | | | | | | |
| Emphysema | | | | | | | | | |

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| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Environmental Sensitivities | | | | | | | | | |

## REVIEW OF SYMPTOMS

**Highlight in blue or tick** those items that applied to you in the ***past***.
**Highlight in yellow or circle** those that ***presently*** apply.

### GENERAL

- ❑ Fever
- ❑ Chills/Cold all over
- ❑ Aches/Pains
- ❑ General Weakness
- ❑ Difficulty sweating
- ❑ Excessive Sweating
- ❑ Swollen Glands
- ❑ Cold hands & Feet
- ❑ Fatigue
- ❑ Difficulty falling asleep
- ❑ Sleepwalker
- ❑ Nightmares
- ❑ No dream recalls
- ❑ Early waking
- ❑ Daytime sleepiness
- ❑ Distorted vision

### SKIN:

- ❑ Cuts heal slowly
- ❑ Bruise easily
- ❑ Rashes
- ❑ Pigmentation
- ❑ Changing Moles
- ❑ Calluses
- ❑ Eczema
- ❑ Psoriasis
- ❑ Dryness/cracking skin
- ❑ Oiliness
- ❑ Itching
- ❑ Acne
- ❑ Boils
- ❑ Hives
- ❑ Fungus on Nails
- ❑ Peeling Skin
- ❑ Shingles
- ❑ Nails Split
- ❑ White Spots/Lines on Nails
- ❑ Crawling Sensation
- ❑ Burning on Bottom of Feet
- ❑ Athletes Foot
- ❑ Cellulite
- ❑ Bugs love to bite you
- ❑ Bumps on back of arms & front of thighs
- ❑ Skin cancer
- ❑ Strong body odor

**Is your skin sensitive to?**

- ❑ Sun
- ❑ Fabrics
- ❑ Detergents
- ❑ Lotions/Creams

### HEAD:

- ❑ Poor Concentration
- ❑ Confusion
- ❑ Headaches:
  - ❑ After Meals
  - ❑ Severe
  - ❑ Migraine
  - ❑ Frontal
  - ❑ Afternoon
  - ❑ Occipital
  - ❑ Afternoon
  - ❑ Daytime
  - ❑ Relieved by:
    - ❑ Eating Sweets
- ❑ Concussion/Whiplash
- ❑ Mental sluggishness
- ❑ Forgetfulness
- ❑ Indecisive
- ❑ Face twitch
- ❑ Poor memory
- ❑ Hair loss

### EYES:

- ❑ Feeling of sand in eyes
- ❑ Double vision
- ❑ Blurred vision
- ❑ Poor night vision
- ❑ See bright flashes
- ❑ Halo around lights
- ❑ Eye pains
- ❑ Dark circles under eyes
- ❑ Strong light irritates
- ❑ Cataracts
- ❑ Floaters in eyes
- ❑ Visual hallucinations

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## EARS:

- ❑ Aches
- ❑ Discharge/Conjunctivitis
- ❑ Pains
- ❑ Ringing
- ❑ Deafness/Hearing loss
- ❑ Itching
- ❑ Pressure
- ❑ Hearing aid
- ❑ Frequent infections
- ❑ Tubes in ears
- ❑ Sensitive to loud noises
- ❑ Hearing hallucinations

## NOSE/SINUSES

- ❑ Stuffy
- ❑ Bleeding
- ❑ Running/Discharge
- ❑ Watery nose
- ❑ Congested
- ❑ Infection
- ❑ Polyps
- ❑ Acute smell
- ❑ Drainage
- ❑ Sneezing spells
- ❑ Post nasal drip
- ❑ No sense of smell
- ❑ Do the change of seasons tend to make your symptoms worse? Yes/No

**If yes, is it worse in the:**

- ❑ Spring
- ❑ Summer
- ❑ Fall
- ❑ Winter

## MOUTH:

- ❑ Coated tongue
- ❑ Sore tongue
- ❑ Teeth problems
- ❑ Bleeding gums
- ❑ Canker sores
- ❑ TMJ
- ❑ Cracked lips/ corners
- ❑ Chapped lips
- ❑ Fever blisters
- ❑ Wear dentures
- ❑ Grind teeth when sleeping
- ❑ Bad breath
- ❑ Dry mouth

## THROAT:

- ❑ Mucus
- ❑ Difficulty swallowing
- ❑ Frequent hoarseness
- ❑ Tonsillitis
- ❑ Enlarged glands
- ❑ Constant clearing of throat
- ❑ Throat closes up

## NECK:

- ❑ Stiffness
- ❑ Swelling
- ❑ Lumps
- ❑ Neck glands swell

## CIRCULATION/RESPIRATION:

- ❑ Swollen ankles
- ❑ Sensitive to hot
- ❑ Sensitive to cold
- ❑ Extremities cold or clammy
- ❑ Hands/Feet go to sleep/numbness/tingling
- ❑ High blood pressure
- ❑ Chest pain
- ❑ Pain between shoulders
- ❑ Dizziness upon standing
- ❑ Fainting spells
- ❑ High cholesterol
- ❑ High triglycerides
- ❑ Wheezing
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Low exercise tolerance
- ❑ Frequent coughs
- ❑ Breathing heavily
- ❑ Frequently sighing
- ❑ Shortness of breath
- ❑ Night sweats
- ❑ Varicose veins/spider veins
- ❑ Mitral valve prolapses
- ❑ Murmurs
- ❑ Skipped heartbeat
- ❑ Heart enlargement
- ❑ Angina pain
- ❑ Bronchitis/Pneumonia
- ❑ Emphysema
- ❑ Croup
- ❑ Frequent colds
- ❑ Heavy/tight chest
- ❑ Prior heart attack? When___/___/_____
- ❑ Phlebitis

## GASTROINTESTINAL

- ❑ Peptic/Duodenal Ulcer
- ❑ Poor appetite
- ❑ Excessive appetite
- ❑ Gallstones
- ❑ Gallbladder pain

- ❑ Nervous stomach
- ❑ Full feeling after small meal
- ❑ Indigestion
- ❑ Heartburn
- ❑ Acid Reflux
- ❑ Hiatal Hernia
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Abdominal Pains/Cramps
- ❑ Gas
- ❑ Diarrhea
- ❑ Constipation
- ❑ Changes in bowels
- ❑ Rectal bleeding
- ❑ Tarry stools
- ❑ Rectal itching
- ❑ Use laxatives
- ❑ Bloating
- ❑ Belch frequently
- ❑ Anal itching
- ❑ Anal fissures
- ❑ Bloody stools
- ❑ Undigested food in stools

## KIDNEY/URINARY TRACT:

- ❑ Burning
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Night time urination
- ❑ Problem passing urine
- ❑ Kidney pain
- ❑ Kidney stones
- ❑ Painful urination
- ❑ Bladder infections
- ❑ Kidney infections
- ❑ Syphilis
- ❑ Bedwetting
- ❑ Have trichomonas

## WOMEN'S HISTORY (for women only)

- ❑ Fibrocystic breasts
- ❑ Lumps in breast
- ❑ Fibroid Tumors/Breast
- ❑ Spotting
- ❑ Heavy periods
- ❑ Fibroid Tumors/Uterus

## WOMEN'S HISTORY (for women only)

- ❑ Painful periods
- ❑ Change in period
- ❑ Breast soreness before period
- ❑ Endometriosis
- ❑ Non-period bleeding
- ❑ Breast soreness during period
- ❑ Vaginal dryness
- ❑ Vaginal discharge
- ❑ Partial/total hysterectomy
- ❑ Hot flashes
- ❑ Mood swings
- ❑ Concentration/Memory Problems
- ❑ Breast cancer
- ❑ Ovarian cysts
- ❑ Pregnant
- ❑ Infertility
- ❑ Decreased libido
- ❑ Heavy bleeding
- ❑ Joint pains
- ❑ Headaches
- ❑ Weight gain
- ❑ Loss of bladder control
- ❑ Palpitations

## 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
- ❑ Diminished/poor libido
- ❑ Infertility
- ❑ Lumps in testicles
- ❑ Sore on penis
- ❑ Genital pain
- ❑ Hernia
- ❑ Prostate cancer
- ❑ Low sperm count
- ❑ Difficulty obtaining erection
- ❑ Difficulty maintaining an erection
- ❑ Nocturia (urination at night)
- ❑ How many times at night? ____

- ❑ Urgency/Hesitancy/Change in Urinary Stream
- ❑ Loss of bladder control

## JOINT/MUSCLES/TENDONS

- ❑ Pain wakes you
- ❑ Weakness in legs and arms
- ❑ Balance problems
- ❑ Muscle cramping

- ❑ Head injury
- ❑ Muscle stiffness in morning
- ❑ Damp weather bothers you
- ❑ Been addicted to drugs
- ❑ Extremely shy

## EMOTIONAL:

- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Blackouts/Amnesia
- ❑ Had prior shock therapy
- ❑ Frequently keyed up and jittery
- ❑ Startled by sudden noises
- ❑ Anxiety/Feeling of panic
- ❑ Go to pieces easily
- ❑ Forgetful
- ❑ Listless/groggy
- ❑ Withdrawn feeling/Feeling 'lost'
- ❑ Had nervous breakdown
- ❑ Unable to concentrate/short attention span
- ❑ Vision changes
- ❑ Unable to reason
- ❑ Considered a nervous person by others
- ❑ Tends to worry needlessly
- ❑ Unusual tension

## EMOTIONAL (CONTINUED)

- ❑ Frustration
- ❑ Emotional numbness
- ❑ Often break out in cold sweats
- ❑ Profuse sweating
- ❑ Depressed
- ❑ Previously admitted for psychiatric care
- ❑ Often awakened by frightening dreams
- ❑ Family member had nervous breakdown
- ❑ Use tranquilizers
- ❑ Misunderstood by others
- ❑ Irritable/
- ❑ Feeling of hostility/volatile or aggressive
- ❑ Fatigue
- ❑ Hyperactive
- ❑ Restless leg syndrome
- ❑ Considered clumsy
- ❑ Unable to coordinate muscles
- ❑ Have difficulty falling asleep
- ❑ Have difficulty staying asleep
- ❑ Daytime sleepiness
- ❑ Am a workaholic
- ❑ Have had hallucinations
- ❑ Have considered suicide
- ❑ Have overused alcohol
- ❑ Family history of overused alcohol
- ❑ Cry often
- ❑ Feel insecure
- ❑ Have overused drugs

**PLEASE SEND THIS FORM 2 DAYS IN ADVANCE OF YOUR APPOINTMENT**

## EMOTIONAL SYMPTOMS

a. Describe any important event that affected you greatly.
(anger, grief, jealousy, need for consolation, intolerance to contradiction, humiliation, regret, disappointment, silent grief, weeps easily, cannot weep, sighing, mood swings, sadness alternating with cheerfulness, irritability, crazy laughter)

_____

_____

_____

b. How did it affect you in the past, how does it affect you now?

_____

_____

_____

c. Discuss your concentration ability and memory for certain events?

_____

_____

_____

d. Do you have emotional indifference to: loved ones, pleasure, anything?

_____

e. Does music have an influence on you? (Desire for sad music, emotionally sensitive to music, affected by loud rhythmic music)

_____

_____

f. Do you suffer with any fears?

(dark, storms, high places, dogs, diseases, narrow places, water, noise, spiders, being poisoned, accidents, being injured, something bad will happen etc.)

_____

_____

_____

g. Do you suffer with anxiety? (About your own health, family health, poverty, death)

_____

_____

_____

h. Can you describe your home circumstances and important relationships**?**

_____

_____

_____

Dr A. de Pontes
MTECH (hom) DUT, CFMP, Pg Dip Acu.

**PLEASE SEND THIS FORM 2 DAYS IN ADVANCE OF YOUR APPOINTMENT**

## DENTAL HISTORY

| | Yes | No |
|---|---|---|
| Problem with sore gums (gingivitis)? | | |
| Ringing in the ears (tinnitus)? | | |
| Have TMJ (temporal mandibular joint) problems? | | |
| Metallic taste in mouth? | | |
| Problems with bad breath (halitosis) or white tongue (thrush)? | | |
| Previously or currently wear braces? | | |
| Problems chewing? | | |
| Floss regularly? | | |
| Do you have amalgam dental fillings? How many? | | |
| Did you receive these fillings as a child? | | |

List your approximate age and the type of dental work done from childhood until present:

| Age | Type of dental work: | Health Problems following dental work? (describe) |
|---|---|---|
| | | |
| | | |
| | | |

## GASTROINTESTINAL SYSTEM

a. Do you have regular bowel movements?

_____

_____

b. Are they dependent on what you eat?

_____

c. How does your emotional state affect your bowel movement (stress, worry)

_____

_____

d. Do you suffer from bloating, belching or heartburn? When? What aggravates the symptoms, what can you do to prevent or improve the symptoms?

_____

_____

_____

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**PLEASE SEND THIS FORM 2 DAYS IN ADVANCE OF YOUR APPOINTMENT**

e. Any symptoms associated with bowel condition? (insomnia, fatigue, irritability, brain fog, PMS)

_____

_____

_____

Do you suffer with hemorrhoids or bleeding with stool? _____

## SKIN SYMPTOMS

Please describe them and attach a picture.

a. Are they dry, moist, oozing, colour, itchy?

_____

_____

b. What is the nature of the discharge?

_____

_____

c. When? After a vaccination or after a grief?

_____

_____

d. What if anything precipitated your skin condition? What makes it better or worse? (emotions, heat, cold, showering, scratching)

_____

_____

e. Do you or have you suffered with acne, boils or suppurative tendencies?

_____

_____

f. Do you have a tendency to suffer with warts, tumors or chilblains?

_____

_____

g. Is your skin generally dry or greasy?

_____

_____

h. Do you sweat easily? From where? When?

_____

_____

i. Do you have any skin problems like eczema, warts, tumors, psoriasis or unexplained eruptions?

j. Do you have any ingrown toenails, or hangnails?

_____

_____

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**PLEASE SEND THIS FORM 2 DAYS IN ADVANCE OF YOUR APPOINTMENT**

**How much of the following do you consume each week?**

| | |
|---|---|
| Candy | |
| Cheese | |
| Chocolate | |
| Cups of coffee containing caffeine | |
| Cups of decaffeinated coffee or tea | |
| Cups of hot chocolate | |
| Cups of tea containing caffeine | |
| Diet soda | |
| Ice cream | |
| Salty foods | |
| Slices of white bread (rolls/bagels, etc) | |
| Soda with caffeine | |
| Soda without caffeine | |

## SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Do you:

- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Have problems with insomnia?
- ❑ Snore?
- ❑ Use sleeping aids?

a) Do you wake up frequently? _____

b) What time? _____

c) Are you restless? _____

d) Why can't you sleep? (overactive mind, worries, pain)

_____

e) What time do you wake? _____

f) How do you feel? (tired, grumpy, depressed, energetic) In what position do you sleep in?

g) What about dreams (reoccurring, violent, sensual etc.)

_____

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**PLEASE SEND THIS FORM 2 DAYS IN ADVANCE OF YOUR APPOINTMENT**

## EXERCISE HISTORY

Do you exercise regularly? Yes____ No____

| If yes, please indicate: | Times/week | | | | Length of session | | | |
|---|---|---|---|---|---|---|---|---|
| **Type of exercise** | 1x | 2x | 3x | 4x/+ | ≤15 | 16-30 min | 31-45 min | >45 |
| Jogging/Walking | | | | | | | | |
| Aerobics | | | | | | | | |
| Strength Training | | | | | | | | |
| Pilates/Yoga/Tai Chi | | | | | | | | |
| Sports (tennis, golf, water sports, etc) | | | | | | | | |
| Other (please indicate) | | | | | | | | |

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

_____

_____

## SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

### STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?_____

Have you ever contemplated suicide? Yes____ No____

If yes, how often? _____ When was the last time?_____

How? (thoughts, by shooting, by jumping, hanging, knife or overdose)

_____

_____

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**PLEASE SEND THIS FORM 2 DAYS IN ADVANCE OF YOUR APPOINTMENT**

Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g., pastor, psychologist, etc.)_____

Did it help?_____

How well have things been going for you?

| | Very well | Fine | Poorly | Very poorly | Does not apply |
|---|---|---|---|---|---|
| At school | | | | | |
| In your job | | | | | |
| In your social life | | | | | |
| With close friends | | | | | |
| With sex | | | | | |
| With your attitude | | | | | |
| With your boyfriend/girlfriend | | | | | |
| With your children | | | | | |
| With your parents | | | | | |
| With your spouse | | | | | |

**Which of the following provide you emotional support?** *Check all that apply*

❑ Spouse Family ❑ Friend ❑ Religious/Spiritual ❑ Pets ❑ Other _____

Have you ever been involved in abusive relationships in your life? Yes ___ No___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No___

Did you feel safe growing up? Yes ___ No___

Was alcoholism or substance abuse present in your childhood home? Yes ___No___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No__

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

**STRESS**

**Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life?**

| Stressful event | Date |
|---|---|
| 1) | |
| 2) | |
| 3) | |
| 4) | |
| 5) | |

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**PLEASE SEND THIS FORM 2 DAYS IN ADVANCE OF YOUR APPOINTMENT**

Do you practice meditation or relaxation techniques? Yes ___ No ___

If yes, how often? _____

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other

Hobbies and leisure activities:

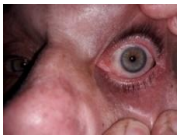
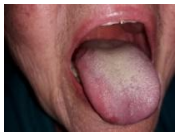
_____

_____

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here? Yes_____ No_____

Please send me photos of your eyes and tongue – left and right eyes separate – open wide - close up clear photo. Tongue must be out as far as possible - close up clear photo. Also send me a full-length photo of yourself against a plain background.

Some examples:

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and well-being.

***PLEASE FORWARD YOUR COMPLETED FORM AND PHOTOS TO reception@drdepontes.co.za and anthony@drdepontes.co.za***

***Please return your form 2 days prior to your appointment, for the doctor to assess your case. Failure to do so will result in your appointment being postponed by 1 week.***

***Thank you for your co-operation.***

Sincerely,

*Dr Anthony de Pontes*

Dr A. de Pontes

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