Patient History Report

My Medical History [100%]

1	Please briefly tell us your goals and reasons for using Metabolic Code hoping to feel better and more energetic on a consistant basis	
2	Please describe any major medical concerns you currently have. I do not have any major medical concerns	
3	Are you currently suffering from any of the following conditions? (Chose as many as apply) I do not suffer from any of these	
4	Any previous or current cancer? (Choose as many as apply) I do not/have not had cancer	
5	List any other current medical problems not mentioned above: N/A	
6	List all medications that you take regularly with the dosage and how often you take them. (Including aspirin, birth control pills, etc.) If none, type “None”. Advil liqui-gels - take 3/day 200 mg/ea. 14 days of month (typicall), Progesterone Cream 2xday 100 mg 1/8 or 1/4 tsp. depending	
7	List all vitamins, minerals, herbs and fish oils with the dosage, and how often you take them. If none, type “None” don't take regularily.	
8	List all drug allergies and the symptoms that you experience. (Such as penicillin/rash, etc.) If none, type “No drug allergies” no drug allergies	
9	Do you have any seasonal allergies?	No
10	Please list any prior hospitalizations. (Give reason for hospitalizations and approximate dates) pre-term labor w/twins-56 days in hospital - 2006. had appendix out - 2009??	
11	Have you ever had surgery for any of the following reasons? (Choose as many as apply) Appendectomy (appendix), Cesarean section	
12	List any other surgeries not mentioned above. (Give type of surgery and the approximate dates) none	
13	Have you had significant contact with any of the following? (Choose as many as apply)	

	Not applicable	
14	What is your height in feet and inches? Ex. (5-6) 5-3	
15	Are you still menstruating?	Yes
16	Have you ever been diagnosed with: Not Applicable	
17	Were the results of you last mammogram normal? Yes	
18	What was the date of your last mammogram? summer 2016	
19	Were the results of your last pap smear normal? Yes	
20	What was the date of your last pap smear? not sure	
21	Please provide any additional information you wish to share with your doctor. Have tried: accupuncture, progetrerone cream, testosterone cream and pellet, clean eating, flaxseed, primrose, etc. Hoping for some relief and have yet to find.	

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My Lifestyle [100%]

22	What is your marital status? Married/Partnered
23	How many cans of soft drink do you have on an average day? I don't drink soft drinks
24	How many cups of coffee do you have on an average day? 1 or 2
25	If you smoke cigarettes, how many years have you been smoking? I don't smoke
26	If you smoke cigarettes, approximately how many packs per day? I don't smoke
27	If you quit smoking cigarettes, how many years ago did you quit? I never smoked
28	Are you currently using recreational or illegal drugs? No
29	Are you currently employed? Yes
30	Briefly describe the type of work you do. Broker/Realtor
31	What was the highest level of school you completed? Bachelors
32	If you do aerobic exercise, how many times per week? 3 to 4
33	If you do aerobic exercise, what type and for how long? walking, aerobic dancing - 3 mins.
34	If you do weight lifting exercise, how many times per week? I don't do any strength building exercises
35	If you do weight lifting exercise, what type and for how long? N/A
36	If you meditate, how many times per week?

	I don’t meditate
37	What is your sexual orientation?
	Heterosexual

My Family | (Mother) [100%]

38	Illnesses/Conditions: None of the Above
39	Age (current age if living / age at death if deceased): 71
40	This relative is: Living

My Family | (Father) [100%]

41	Illnesses/Conditions: Asthma
42	Age (current age if living / age at death if deceased): 73
43	This relative is: Living

My Family | (Maternal Grandmother) [100%]

44	Illnesses/Conditions: Lung Cancer
45	Age (current age if living / age at death if deceased): 76
46	This relative is: Deceased

My Family | (Biological Sister) [100%]

47	Illnesses/Conditions: None of the Above
48	Age (current age if living / age at death if deceased): 50
49	This relative is: Deceased

My Family | (Child) [100%]

50	Illnesses/Conditions: None of the Above
51	Age (current age if living / age at death if deceased): 10
52	This relative is: Living

My Family | (Child) [100%]

53	Illnesses/Conditions: None of the Above
54	Age (current age if living / age at death if deceased): 10
55	This relative is: Living

My Family | (Paternal Grandmother) [100%]

56	Illnesses/Conditions: None of the Above
57	Age (current age if living / age at death if deceased): 87
58	This relative is: Deceased

My Family | (Paternal Grandfather) [100%]

59	Illnesses/Conditions: Asthma, Emphysema
60	Age (current age if living / age at death if deceased): 70
61	This relative is: Deceased

My Family [100%]

62	Illnesses/Conditions: Lung Cancer
63	Age (current age if living / age at death if deceased): 65
64	This relative is: Deceased

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Metabolics [100%]

Basic Health

65	Have you been told you have pre-diabetes or have insulin resistance (a fasting blood sugar level of greater than 99)?	No
66	Do you drink alcoholic beverages, more than 1-2 glasses of wine, 1-2 beers or 1-2 shots of alcohol daily?	No
67	Do you have food allergies or food intolerances?	No
68	Are you under chronic stress and/or are you anxious and have anxiety?	Yes
69	Do you have food cravings often?	No
70	Do you exercise regularly?	Yes
71	Have you tested positive for the MTHFR (methylenetratrahydrofolate reductase) gene SNP or have folate deficiency?	No
72	Have you tested positive for heavy metals?	No

Drug-Induced Nutrient Depletion

73	Do you take acetaminophen (Tylenol) regularly?	No
74	Are you taking antibiotics?	No
75	Are you taking medications for anxiety, to relax or for sleep?	No
76	Are you taking antihistamines?	No
77	Are you prescribed anticonvulsant drugs for seizures or other health condition?	No
78	Are you taking medications for depression or mood imbalances?	No
79	Are you taking medications for your blood sugar levels or diabetes?	No
80	Do you take aspirin regularly?	No
81	Are you taking medications for osteoporosis prevention and/or bone health?	No
82	Are you taking oral or inhaled corticosteroids ("steroids")?	No
83	Are you taking a medication for your cholesterol called a "statin"?	No
84	Are you taking any other medications to help lower your cholesterol other than a "statin"?	No
85	Are you taking "fluid pills" or diuretics?	No
86	Are you taking a drug for your heart called digitalis or Lanoxin?	No

87	Are you taking synthetic hormonal replacement therapy, including synthetic estrogens (including Premarin or conjugated estrogen) and/or progestins? This does not include testosterone or bio-identical hormone replacement.	No
88	Are you prescribed a beta-blocker for your heart or blood pressure?	No
89	Are you taking an ACE inhibitor or ARB for your blood pressure or heart condition?	No
90	Are you taking potassium prescribed by your doctor?	No
91	Are you taking prescribed medications to help improve your memory?	No
92	Do you take NSAIDs (non-steroidal anti-inflammatory drugs) like ibuprofen (Advil) or naproxen (Aleve) regularly?	Yes
93	Are you taking oral contraceptives (birth control "pills")?	No
94	Are you prescribed drugs for pain called opiates, including hydrocodone, codeine, morphine, meperidine (Demerol), oxycodone (Oxycontin)?	No
95	If yes to taking opiates, do these pain medications also contain acetaminophen?	No
96	Are you prescribed medications for thyroid?	No
Triad 1 - Adrenal High		
97	Are you easily irritated and snap at family and co-workers?	No
98	Do you feel overcommitted throughout the day?	Yes
99	Do you feel there is too much stress in your life?	Yes
100	Do you usually eat more than 50% of your calories after 5pm?	No
101	Do you recover poorly from injury or illness?	No
102	Has your ability to exercise decreased?	Yes
103	Do you get upset easily, causing you to become tired and exhausted?	Yes
104	Do you easily get shaken, startled or get goose bumps?	Yes
Triad 1 - Adrenal Low		
105	Do you crave salt or comfort foods in the late afternoon or evening?	Yes
106	Do you take in more than the equivalent of 3 cups of coffee a day in caffeine for energy?	No
107	Do you get dizzy when standing up?	No
108	Do you feel emotionally flat, less able to feel happiness or joy?	Yes
109	Is your short-term memory worse than it used to be?	Yes

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Triad 1 - Pancreas - Blood sugar balance

110	Do you feel irritable if a meal is missed or get anxious/nervous/shaky if you go more than 4 hours without eating?	Yes
111	Do you crave carbohydrates (breads, pasta, crackers, chips, cookies, fruit drinks and sodas)?	Yes
112	Are you more than 20 pounds over your ideal body weight?	No
113	Do you get a headache if you go too long without eating or relieved by sweets or alcohol?	No
114	Do you get tired after eating a big meal?	No
115	Do you wake up at night craving carbohydrates like sweets, cookies, chips, crackers or breads?	No
116	Have you been told by your doctor that you are insulin resistant, pre-diabetic or that you are diabetic?	No
117	Do you get periodic energy crashes during the course of the day that is relieved by caffeine or food?	No
118	Do you get night sweats?	No
119	Is your memory, concentration or focus poor?	Yes

Triad 1 - Thyroid High

120	Do you have a history of heart palpitations (abnormally rapid or irregular heart beat)?	No
121	Do you flush easily?	No
122	Do your hands shake or tremble?	No
123	Do you eat a lot but can’t gain weight?	No
124	Do you have high energy levels, followed by exhaustion or extreme tiredness?	No
125	Does your heart beat 90/min or above at rest? If so, based on your questionnaire answer, you should seek medical attention.	No

Triad 1 - Thyroid Low

126	Do you usually feel exhausted and tired from morning to night?	Yes
127	Do you have trouble getting up in the morning?	Yes
128	Do you have dry skin, brittle hair and/or nails?	No
129	Do you have difficulty losing weight regardless of diet/exercise?	No
130	Do you have cold hands and/or feet?	Yes

131	Are your eyebrows and hair thinning, especially around the edges?	Yes
132	Does your body temperature usually run low (less than 98 degrees F)?	Yes
Triad 2 - Brain		
133	Do you usually have difficulty falling asleep?	No
134	Do you have trouble with replaying events over in your head that keep you from falling asleep?	No
135	Are you a restless sleeper, tossing or awakening during the night?	Yes
136	Do you snore to the point that other people comment?	No
137	Have you been told by your doctor that you have sleep apnea?	No
138	Do you sleep 5 hours or less a night?	No
139	Do you sleep between 5 and 7 hours a night?	Yes
140	Do you sleep more than 9 hours a night?	No
141	Do you eat past being full, attempting to shut off an emotional craving in your head?	No
142	Do you have frequent mood swings?	No
143	Do your calf muscles cramp while walking or do you experience restless leg syndrome at night?	No
Triad 2 - Gut		
144	Have you ever taken antibiotics for acne or have you ever taken antibiotics for 2 months or longer?	No
145	Have you taken cortisone-type ("steroid") drugs, like cortisone, hydrocortisone, prednisone) periodically in your lifetime?	No
146	Do you use aspirin, ibuprofen (Advil, Motrin), naproxen (Aleve, Naprosyn) or acetaminophen (Tylenol) regularly or take prescription NSAIDs (non-steroidal anti-inflammatory drugs)?	Yes
147	Do you get athlete's foot, "jock itch" or fungus on skin or nails easily?	No
148	Do you get symptoms from damp, muggy days, or moldy places - like being tired, trouble breathing or runny nose/sneezing?	No
149	Do you have food intolerances or environmental allergies?	No
150	Do you have mental "fogginess" - like you're pushing a thought through "jello"?	Yes
151	Have you had or do you get skin rashes or eczema?	No
152	Are you frequently constipated, have diarrhea or go back and forth between the two?	No

153	Do you have frequent constipation? (more than once weekly)	No
154	Do you get gassy or bloated easily, especially after eating a meal?	No
Triad 2 - Gut - Stomach Acid High		
155	Do you have stomach pain before or after eating?	No
156	Does stomach pain get worse with stress or emotional upset?	No
157	Have you been diagnosed with an ulcer?	No
158	Are you on H2 blockers or proton pump inhibitors (PPIs)? These drugs are for indigestion and are either prescription or over-the-counter (non-prescription).	No
159	Do you get frequent sinus infections or have you been diagnosed with chronic sinusitis?	No
Triad 2 - Gut - Stomach Acid Low		
160	Do you belch and burp frequently?	No
161	Do you feel full for extended periods of time after eating?	No
162	Do you have a history of anemia (low iron, B12, or folic acid) that doesn't respond well to treatment?	No
Triad 2 - Immune		
163	Do you get frequent sore throats or throat infections?	No
164	Do you get cold sores or fever blisters often?	No
165	Do you have swollen glands often?	No
166	Do you get or have a history of frequent ear infections?	No
167	Is it difficult for you to get over a cold or the "flu"?	No
168	Do you get sick a lot?	No
169	Do you get boils or styes often?	No
170	Do you have itchy, watery eyes often?	No
Triad 2 - Immune Th2		
171	Do you have heavy discharge from your eyes often?	No
172	Do you get itchy in your mouth or throat often?	No
173	Do you clear your throat frequently?	No
174	Do you have post-nasal drip (a runny nose) often?	No

175	Do you sneeze a lot?	No
176	Do you breathe through your mouth?	No
177	Do you have asthma or wheezing?	No
178	Do you have a history of herpes?	No
179	Do you have swollen joints or joint pain?	No
180	Do you usually have a lack of sleep?	No
Triad 3 - Cardiovascular		
181	Do you feel out of breath after walking up a flight of stairs?	No
182	Do you have swelling in your feet and/or ankles?	No
183	Do you experience chest pain while walking?	No
184	Do you have difficulty breathing at night?	No
185	Do you exercise regularly?	Yes
186	Have you been told by your doctor you have high blood pressure?	No
Triad 3 - Neurovascular		
187	Does your head feel “heavy” or imbalanced?	No
188	Do you get light-headed easy or faint?	No
189	Do you have ringing or buzzing in the ears?	No
190	Do you have a tingling or pain sensation on your body without having previous injury?	No
191	Do you have a loss of feeling in hands and/or feet (toes)?	No
192	Do your arms and legs feel too heavy to hold up?	No
193	Do you lose your balance easily?	No
194	Have you ever been told by your doctor that you have shingles?	No
195	Do you have difficulty breathing?	No
Triad 3 - Pulmonary		
196	Do you get chest pain with a deep breath?	No
197	Do you have shortness of breath?	No
198	Do you cough often or have to clear your throat often?	No
199	Is there rattling or mucous in your lungs when you breathe?	No

200	Do you live around people who smoke?	No
201	Have you ever been exposed to asbestos?	No
202	Have you been told by your doctor that you have bronchitis?	No
203	Do you smoke?	No
204	Do you live in an industrialized area with a large amount of pollution?	No
205	Are you intolerant of greasy foods, like fried foods or fatty meats?	No
Triad 4 - Kidney		
206	Do you have cloudy urine?	No
207	Do you have difficulty holding your urine?	No
208	Have you had a history of frequent urinary tract infections or cystitis?	No
209	Do you have swollen glands in neck, groin, or armpits?	No
Triad 4 - Liver		
210	Do you have pain or discomfort in your right side under your rib cage?	No
211	Do you have a light colored or yellowish stool?	No
212	Are the whites of your eyes yellowed?	No
213	Do you have a sour taste in your mouth often?	No
214	Do you have bad breath?	No
215	Do you have excessive body odor?	No
216	Do you use acetaminophen (Tylenol), naproxen (Aleve) or ibuprofen (Advil, Motrin) more than once a week?	Yes
217	Do you have pain or burning when urinating?	No
Triad 4 - Lymph		
218	Have you had lymph nodes removed?	No
219	Do you feel as though your legs have cement in them?	No
220	Do you have irregular cycles?	Yes
Triad 5 - Sex Hormones: Estrogen - Progesterone		
221	Do you have stress incontinence, leaking urine if you cough, sneeze or laugh?	No
222	Do you have tender breasts?	No

223	Do you experience or have symptoms of pre-menstrual syndrome (PMS)?	Yes
224	Do you have headaches related to your cycle?	Yes
225	Do you have recurring yeast infections?	No
226	Has your sex drive decreased?	Yes
227	Is intercourse painful due to vaginal dryness?	Yes
228	Do you have organ prolapse?	No
229	Have you been diagnosed with uterine fibroids?	No
230	Do you have extreme symptoms, such as hot flashes, mood swings or night sweats?	No
231	Have you had trouble getting pregnant?	Yes
232	Do you or have you taken birth control?	No
233	Do you take or use estrogen as hormonal replacement therapy?	No
234	Do you take or use progesterone as hormonal replacement therapy?	Yes
235	Are you going through menopause or have you completed menopause (postmenopausal)?	Yes