Medical Questionnaire

THIS QUESTIONNAIRE IS CONFIDENTIAL AND WILL ASSIST US IN DETERMINING THE MOST SUITABLE TREATMENT PLAN FOR YOU. PLEASE COMPLETE IT THOROUGHLY AS POSSIBLE. THANK YOU.

GENERAL INFORMATION

First name: _____ Last name: _____ Birth date: _____

Age: _____ years old Occupation: _____ Gender: _____ Marital status: _____

Phone number: _____ Email address: _____

Skype ID: _____ WhatsApp: _____ Line ID : _____

How did you hear about us?: _____

Do you any allergies or are you sensitive to any drugs or substances? _____

Emergency contact person: _____ Relationship: _____ Phone number: _____

PAST HEALTH HISTORY

What are your medical and surgical histories? (Including hospitalization, accidents, and surgeries)

_____

_____

_____

Cancer: please specify (organ)_____ Stage: _____

Metastasis to (organ): _____

TOBACCO / ALCOHOL USE

Do you drink alcohol? □ No □Yes If yes, how much and how often?

_____ How long ago and duration: _____

Do you smoke? □ No □Yes If yes, how many cigarettes per day?

_____ How long ago and duration: _____

Are you an ex-smoker? □ No □ Yes If yes, when did you quit? _____

Live with a smoker? (Secondhand Smoke) □ Yes □ No

PRESENT HEALTH

Please describe your current state of health (location of the symptom/s, severity, duration, and signs/symptoms)

_____

_____

Perception and Health Management Pattern

Are you currently receiving treatment for any of these conditions? (Chemotherapy, Radiation, Surgery)

_____

_____

_____

If yes, please describe what kind of treatments, where and when? (Date started, Date finished)

_____

_____

_____

Please attach your medical reports:

Biopsy:: _____ date: _____

PET/CT: _____ date: _____

Ultrasound: _____ date: _____

CT Scan (Computerized Tomography): _____ date: _____

Dental X-ray/Cone Beam CT Scan : _____ date: _____

Blood results: _____ date: _____

Other: _____date: _____

Other: _____date: _____

Current Medicine and supplement

Please provide a list of all current medications, hormone replacement therapies, vitamins, minerals, herbals, supplements, and protein powders being taken.

Name/Description	Dosage/Quantity	Frequency	REASON
Example: Metformin	500mg	2x/day	Diabetes mellitus

Do you have any trouble taking medicines /supplements? □ Yes □ No

If yes , please describe :_____

Dental Assessment:

Do you have an extracted tooth? □ Yes □ No If yes, how many? ____ Which tooth?_____

Do you have root canals? □ Yes □ No If yes, how many? ____ Which tooth?_____

Do you have dental fillings? □ Yes □ No If yes, how many? _____

Which tooth and what type of filling (i.e. amalgam,composite, porcelain, etc.)?

_____

Do you have implants? □ Yes □ No If yes, how many? _____

Which tooth and what type of implant?

_____

Have you ever been diagnosed with gum disease (gingivitis or periodontitis)? □ Yes □ No

Are you currently experiencing any dental issues or concerns □ Yes □ No

If yes, Please specify _____

Nutritional Assessment:

Height _____cm Weight _____ kg BMI: _____

Have you had any recent changes in your weight that concerned you within the past 3 months ? □Yes □ No

If yes, please explain weight loss or gain and by how much?:

_____

Appetite □ Good (eat 3+ meals/day) □ Fair (1-2 meals/day) □ Poor (less than 1 meal/day)

Food intake: _____times a day

Fluid intake: _____liters of water per day

Do you find yourself eating processed foods often? (This includes red and packaged meats, frozen meals, and white bread but excludes homogenized milk and frozen veggies)

□Always □Often □Sometimes □ Rarely □ Never

What kind of diet do you follow?

□ Mediterranean diet □ Ketogenic diet □ Pescatarian diet □ Vegetarian diet □ Vegan diet □ Raw Vegan diet □ Western diet □ Other _____

Please describe your daily meal(s)

_____

Do you drink coffee? If yes, what type of coffee? How many cups per day? _____

Do you drink tea? If yes, what kind of teas? How many cups per day? _____

Any food restriction regarding disease point of view?

Any food restriction regarding religious point of view?

What kind of food do you like?

What kind of food do you dislike?

Do you have any physical conditions that restrict food intake, such as mouth ulcers, difficulty swallowing? If yes please describe.

ELIMINATION PATTERN

How often do you have a bowel movement? Please describe its frequency, character, any discomfort, and any issues with control.

If you take laxatives, what type/brand and how often?

Describe your urinary elimination pattern. How often do you urinate? Do you experience any issues with control?

SLEEP-REST PATTERN:

How many hours of sleep do you average a night? _____ hours.

Sleep onset problems? □ Yes □ No Dreams (nightmares) □ Yes □ No Early awakening? □ Yes □ No

What do you feel after waking **in the morning**? (fresh, headache, drowsy): _____

Are you using any medication for sleeping? □ Yes □ No: if yes please specify : _____

ACTIVITY-EXERCISE PATTERN:

Activities of Daily Living (ADL)
In the past 7 days, have you required assistance from others with everyday activities such as eating, dressing, grooming, bathing, walking, or using the toilet? If yes, please provide a description.

_____

_____

_____

In the past 7 days, have you required assistance from others with tasks such as laundry, housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your medications? If yes, please provide a description.

_____

_____

_____

Do you have any illnesses that affect your movement, such as tiredness or pain when moving? Please specify details.

_____

How many times per week do you exercise?

_____

How many minutes on average do you exercise and what type of exercise?

_____, _____minute

RESPIRATORY

Have you ever experienced any breathing difficulties? This includes conditions such as asthma, emphysema, chronic cough, pneumonia, tuberculosis, or any other lung disorder.

_____

Need oxygen support □ Y □ N

PAIN

Do you experience chronic pain, lasting for 2 months or more continuously? If yes, please describe the symptom(s).

_____

Where in the body does the symptom occur? Is there radiation or extension of the symptom(s) to another area of the body?

_____

On a scale of 0-10, (10 being the worst) how bad is the symptom(s)?

_____

What makes the symptom(s) better or worse?

_____

Does it occur in association with something else (i.e., eating, exertion, movement)?

_____

Does anything make it better?

_____

Value-Belief Pattern

What is your religion? _____

Do you pray, if so how long? _____

Please circle the number (0-10) that best describes your level of distress level over the past few weeks.

□ 0 **(**No distress) □1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □10 **(**Extreme distress)

How often does stress affect your ability to handle various aspects of your life, such as your health, finances, family or social relationships, and work?

□ Never or rarely □ Sometimes □ Often □ Always

How often do you get the social and emotional support you need?

□Always □Often □Sometimes □ Rarely □ Never

If you have stress, then what is your coping mechanism towards stress?

_____

What makes you feel relaxed?

_____

What makes you worry?

_____

Do you believe that a regular holistic health routine will improve your lifestyle?

_____

**** FOR WOMEN ****

Please provide details about your menstrual history, including the onset, length, amount of flow, presence of cramps, bloating, and PMS symptoms, as well as the age of your first period and menopause.

Age at first menstrual period _____

First day of last normal menstrual period _____

Length of entire cycle: _____ days

Age at menopause: _____

Have you undergone hysterectomy? □ Yes □ No If yes, were your ovaries removed? □ Yes □ No

Date of last Pap Smear _____

History of abnormal pap smear? □Yes □No If yes, when? _____

I hereby certify that the above is true in all respects.

Patient's Signature : _____Date _____Time:_____