

What other medical problems or diagnoses are you currently under treatment for?

Problem/diagnosis	Since when?	By whom?

Please list any hospitalizations or surgeries you have had at any time in the past.

Problem/procedure	Approx. year	Complications?

Please list any other significant medical problems you have been treated for in the past, including significant injuries or trauma. _____

Have you ever had a blood transfusion? Y N Under what circumstances _____

Do you have any history, now or in the past, of frequent infections requiring antibiotic therapy or the need to take them prior to dental procedures? Y N Please describe along with name of antibiotic, if you recall: _____

Please list **any** prescription medications, including contraceptives, you are now taking.

Name	Dose/frequency	Since when?	Side effects?

Please list any allergies/intolerances you have to medication.

Medication	Reaction

What nutritional supplements are you taking?

Family History

Do you have a family history of any of the conditions below? Please check and identify who. Include parents, grandparents, siblings, children, aunts and uncles, if known.

Diabetes _____ High blood pressure _____
 Heart disease _____ Thyroid problems _____
 Obesity _____ Mental illness _____
 Asthma/allergies _____
 Alcoholism/drug addiction _____
 Cancer. Also list what type, if known. _____

Other _____

Nutrition and Lifestyle

How many glasses of water do you drink a day? _____

Please describe your typical diet:

<u>Meal</u>	<u>When</u>	<u>What foods</u>
Breakfast	_____	_____
Lunch	_____	_____
Dinner	_____	_____
Snacks	_____	_____

What foods do you crave? _____

How often do you use sugar or consume foods with sugar added (this includes anything with “high fructose corn syrup”)? _____ times a day/week (circle)

How many times a week do you eat out? _____ Where? _____

How often do you skip meals? _____ times a day/week.

What oils do you use for cooking? _____

List any food allergies/intolerances _____

Do you now, or did you ever smoke? Y N Packs per day _____ Since when? _____
If not now smoking, when did you quit? _____ Why? _____

Do you drink alcohol? Y N In what form? _____

How much and how often? _____

Have you or anyone close to you ever felt that you had a problem with alcohol or have you had an argument with them over how much you drink? Y N

Do you drink coffee? Y N Circle: Regular or Decaf How much? _____

Do you drink sodas? Y N What kind? _____ How many a day? _____

Do you now or have you in the past used any recreational drugs Y N

What? _____

How much and for how long? _____

Have you ever in your life been exposed or possibly exposed to significant amounts of pesticides, industrial chemicals, solvents, etc? If so, please give details.

Do you have any mercury amalgam ("silver") dental fillings? Y N How many? _____

Do you have any root canals Y N Which teeth, if known? _____

Any complications? _____

What is your occupation? _____

How many hours a week do you work? _____ Level of education _____

Any hobbies? _____

How else do you relax? _____

On a scale of 1-10 (1=not at all, 10=blissfully happy), how satisfied are you with your:

____ Relationship with spouse/partner (including sex life)? If not applicable, rate your social life?

____ Relationships with other family members?

____ Job/career?

____ Sense of purpose in life?

____ Capacity for fun and play?

____ Sense of spiritual fulfillment?

If any of these are less than 5, what needs to be improved? _____

What spiritual tradition do you follow? _____

Primary Systems: Please place a checkmark next to the problems you are currently experiencing unless asked otherwise.

Gastrointestinal

____ Indigestion/bloating. How soon after meals? _____

____ Nausea/vomiting. When? _____ Any blood? Y N

____ Abdominal pains. Where? _____

____ Any relationship to meals or certain foods? _____

____ Blood or mucous in stool.

____ Irritable bowel syndrome/"spastic colitis"

____ Heartburn/reflux

____ Frequent/excessive gas

How often do you have a bowel movement _____ Circle as appropriate:

Loose Formed Hard Difficult to pass Alternating constipation/diarrhea

Adrenal

- Fatigue. During which part of the day is it the worst? _____
- Hypoglycemia
- Shakiness, lightheadedness, irritability, or moodiness relieved by eating
- Cold hands and feet
- Low blood pressure
- Sensitivity to light
- Dizziness when first standing
- Frequent sore throats/infections that take a long time to go away
- Tiredness on awakening despite "adequate" sleep
- Feel worse after exercise
- Your mother was under a lot of stress or something very stressful happened to her during her pregnancy with you.
- Difficulty falling or staying asleep. Describe _____
- On average, how many hours of sleep do you get a night? _____
- From when to when? _____

Thyroid

- Intolerance to cold
- Hair loss
- Constipation
- Inability to lose weight
- Weight gain unrelated to overeating. _____ pounds over _____ months/years
- Dry skin
- Dry, brittle hair/nails
- High cholesterol
- Carpal tunnel syndrome unrelated to repetitive work stress
- Low body temperature (less than 98 orally or 97.4 under arm)
- Heavy menstrual flow

Hormonal – Women only

If you are post-menopausal or have had a hysterectomy, check off symptoms you had **before** then, as well as those you have now.

- Age when cycles began _____ How many days between periods? _____
- Duration of flow _____ days. No. of pads used at highest flow _____
- Menopause. At what age? _____ Symptoms: _____
 - Irregular cycles. Please describe _____
 - Menstrual cramps
 - Hot flashes/night sweats
 - Premenstrual symptoms
 - Breast tenderness/swelling
 - Bloating
 - Weight gain
 - Fluid retention
 - Mood swings/ depression/irritability
 - Increased appetite/cravings
 - Headaches
 - Other _____
 - Uterine fibroids

Fibrocystic breasts

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Vaginal dryness

Decreased libido

Recurrent vaginitis/yeast infections

How many times have you been pregnant? _____ How many children do you have? _____

Any miscarriages, terminations, stillbirths, or children who died in infancy? Y N Please describe what happened _____

General Systems

Constitutional

Unexplained weight loss. How much? _____ Over how long? _____

Excessive perspiration

Daytime sleepiness

Low grade fevers

Persistent swollen glands

History of anemia

Slow wound healing

Easy bruising

Skin

Rashes

Acne

Eczema/psoriasis

Hives

New or changed mole(s)

Itching

Boils

Infections

Head

Headaches. Describe when and where _____

What makes them better or worse? _____

Any associated symptoms (nausea, visual changes, etc.)? _____

Dizziness or lightheadedness

Eyes

Need glasses/contacts. For (circle): near or far vision

Refractive surgery (Lasik,etc)

Glaucoma

Conjunctivitis/blepharitis

Cataracts

Itching/allergies

Blurry vision

Dry eyes/excessive tearing

Eye pain

Double vision

Other _____

Ears

Hearing loss

Tinnitus (buzzing/ringing)

Excessive wax

Vertigo

Infection

Pain

Nose/Sinuses

- | | |
|---|--|
| <input type="checkbox"/> Chronic congestion/drainage | <input type="checkbox"/> Frequent colds/sinus infections |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> History of fracture/deviated septum |
| <input type="checkbox"/> Loud snoring/stoppage of breathing noted by partner during sleep | |

Mouth and Throat

- | | |
|--|---|
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Bleeding or receding gums/gingivitis |
| <input type="checkbox"/> Canker sores | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Metallic taste |
| <input type="checkbox"/> Thrush | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Grinding/other teeth problems | <input type="checkbox"/> Jaw clicks/TMJ problems |

Neck

- | | |
|---|---|
| <input type="checkbox"/> Goiter(enlarged thyroid) | <input type="checkbox"/> Pain/stiffness |
| <input type="checkbox"/> Other lump or mass | <input type="checkbox"/> Other_____ |

Respiratory

- | | |
|--|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing/asthma |
| <input type="checkbox"/> Bronchitis/colds always go to chest | <input type="checkbox"/> Chest pain with breathing |
| <input type="checkbox"/> Cough. Does it produce phlegm? Y N | What color?_____ |
| <input type="checkbox"/> Any blood in sputum/phlegm | <input type="checkbox"/> Other_____ |

Cardiovascular

- | | |
|---|--|
| <input type="checkbox"/> Chest pressure with activity | <input type="checkbox"/> Palpitations/irregular heart beat |
| <input type="checkbox"/> Murmur | <input type="checkbox"/> Cramping in legs with walking |
| <input type="checkbox"/> Blood clots/phlebitis | <input type="checkbox"/> Varicose veins |

Urinary

- | | |
|--|--|
| <input type="checkbox"/> Frequent urinary infections | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Pain/burning on urination | <input type="checkbox"/> Incomplete emptying |
| <input type="checkbox"/> Incontinence/loss of urine | <input type="checkbox"/> Increased frequency |
| <input type="checkbox"/> Blood in urine | |

Reproductive

- | | |
|---|--|
| <input type="checkbox"/> History of sexually transmitted disease. When_____ | |
| What type?_____ | Treatment?_____ |
| <input type="checkbox"/> Infertility, male or female | <input type="checkbox"/> Decrease libido |
| <input type="checkbox"/> Loss of sexual function | <input type="checkbox"/> Other_____ |

Women

- | | |
|--|------------|
| <input type="checkbox"/> History of abnormal Pap smear | When?_____ |
| Treatment and outcome_____ | |

When was your last Pap? _____

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___ History of abnormal mammogram When? _____
Outcome _____

Men

___ Urethral discharge
___ Diagnosed prostate problems
___ Decreased urinary flow
___ Erectile difficulties
___ History of sexually transmitted disease When? _____
What type? _____ Treatment? _____
___ Involuntary loss of urine
___ History of elevated PSA
___ Incomplete emptying
___ Decreased libido
How many times do you need to get up at night to urinate? _____

Musculoskeletal

___ Joint pain/arthritis Where _____
___ Persistent muscular pain Where _____
___ Diagnosed with fibromyalgia By whom? _____
___ Persistent pain from an injury Describe _____
___ Tendonitis/bursitis
___ Muscle spasms/cramps
___ Back pain/sciatica
___ Osteoporosis/osteopenia

Neurologic

___ Numbness/tingling
___ Seizures
___ Memory impairment
___ Muscular weakness
___ Speech problems
___ Poor concentration/"brain fog"
___ Fainting spells
___ Dizziness
___ Tremors
___ Loss of balance/coordination
___ Visions/hallucinations

Psychologic

Answers here are very helpful to me but do not need to be answered if you are not comfortable doing so at this time.

Are you in counseling? Y N Around what issues _____

Are you being treated with medication for a mental health problem? Y N

Have you been in the past? Y N

If yes to either of the above, please give details _____

Please check any of the following you are now experiencing;

___ Anxiety
___ Easily angered or tearful
___ Considered or fantasized about suicide
___ Depression
___ Feeling overwhelmed or hopeless

Yeast Questionnaire

Total score gives us the probability of intestinal and/or sinus yeast overgrowth in your case.

Point score (add up and total below):

- 50 ___ Have you ever been treated for acne with antibiotics for one month or longer?
- 50 ___ Have you ever taken antibiotics for any problem for two consecutive months or been treated with shorter courses 3 or more times in a 12 month period?
- 6 ___ Have you ever been treated with a "broad-spectrum" antibiotic (something other than a penicillin-related drug), for even a single course?
- 25 ___ Have you ever had chronic prostatitis or recurrent yeast vaginitis?

- 15 ___ Have you been pregnant 2 or more times?
- 5 ___ Only once?

- 25 ___ Have you ever taken birth control pills for over one year?
- 15 ___ If not, for any length of time?

- 15 ___ Have you ever taken cortisone drugs like prednisone?

- 15 ___ Do perfumes, chemicals, pesticides, etc., REALLY bother you?
- 15 ___ How about cigarette smoke?

- 20 ___ Do you crave sugar and/or breads?
- 20 ___ Have you had a fungal infection, such as "jock itch," athlete's foot, or a skin or nail infection, that was difficult to treat?
- 15 ___ Do you feel worse on damp days or in moldy places?

_____ **Total (a score of 70 or greater indicates a high probability of yeast related problems)**