New Patient Optimal Wellness Questionnaire

Name _____
Last First Middle

Date of Birth_____ Age _____

Mailing Address _____
Street City State Zip

Preferred Phone_____ Email_____

Emergency Contact _____
Name Relationship Phone

Primary Care Physician _____
Name City

Preferred Pharmacy _____
Name City

Compounding Pharmacy (*if any*) _____
Name City

Highest Education Level _____

Occupation (if retired, what was your occupation) _____

What is your main health concern or wellness goal?

_____

_____

_____

Health History

Current Medical Conditions

_____ _____
_____ _____
_____ _____
_____

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Past Medical Conditions (*approximate date*)

_____ _____
_____ _____
_____ _____

NONE

Surgeries (*approximate date*)

_____ _____
_____ _____
_____ _____

NONE

Medications/Vitamins/Supplements

_____ NONE
_____ _____
_____ _____
_____

Allergies

_____	☐ Rash	☐ Upset Stomach	☐ Wheezing	Other
_____	☐ Rash	☐ Upset Stomach	☐ Wheezing	☐ Other
_____	☐ Rash	☐ Upset Stomach	☐ Wheezing	☐ Other
_____	☐ Rash	☐ Upset Stomach	☐ Wheezing	☐ Other

NONE

Family History

Diabetes
Hypertension
Heart Disease
Cancer
Other _____

Social History

Marital Status:
- Single
- Married
- Divorced
- Widowed

Do you smoke?
- Yes – How much?_____
- No

Do you drink alcohol?
- Yes – How much?____
- No

Do you use any narcotics?
- Yes – How much? ____
- No

Do you exercise regularly?
- Yes – What type of exercise?_____
- No

Do you have any amalgam (silver) fillings or root canals?
- Yes
- No

Where were you born? _____

Did you grow up or worked on a farm? _____

Have you had unusual exposure to environmental toxins or chemicals, such as pesticides, herbicides or any chemicals?_____

Have you had any of the following (*circle if applicable*):

CT scan, PET scan, Xray, heart calcium scoring scan, mammogram, MRI gadolinium

Review of Systems

Gastrointestinal
- GERD (reflux
- Ulcer
- Gluten Sensitivity
- Celiac Disease

Irritable Bowel
Frequent Constipation
Frequent Diarrhea
Other _____

Cardiovascular
High Blood Pressure
High Cholesterol
Heart Attack
Other Heart Disease
Stroke
Arrhythmia (irregular heartbeat)
Other_____

Metabolic/Endocrine
Type I Diabetes

Inflammation/Autoimmune
Chronic Fatigue Syndrome
Fibromyalgia
Rheumatoid Arthritis
Lupus (SLE)
HIV/AIDS
History of Severe
Infection_____
Frequent Infections
Food Allergies
Multiple Chemical Sensitivities
Latex Allergy
Other _____

Respiratory
Chronic Sinusitis
Asthma
Sleep Apnea
Bronchitis
Emphysema
Pneumonia
Tuberculosis
Other _____

Skin
Eczema
Psoriasis
Acne
Rosacea
Other_____

Neurologic/Psychiatric
Depression
Anxiety
Bipolar Disorder
Schizophrenia
Frequent Headaches

Type II Diabetes
Hypoglycemia
Insulin Resistance or Pre – Diabetes
Hypothyroidism
Hyperthyroidism
Polycystic Ovary Syndrome (PCOS)
Infertility
Unintended Weight Gain
Unintended Weight Loss
Frequent Weight Fluctuations
Bulimia
Anorexia
Binge Eating
Night Eating
Other _____

Migraines
ADHD
Autism
Mild Cognitive Impairment
Memory Problems
Parkinson's Disease
Multiple Sclerosis
ALS
Seizures
Other _____

Blood Disorders
Bleeding Gums
Bruising
Anemia
Deep Venous Thrombosis (DVT)
Pulmonary Embolus (PE)
Blood Clotting Disorder
Other _____

Cancer
Breast Cancer
Colon Cancer
Ovarian Cancer
Prostate Cancer
Lung Cancer
Skin Cancer
Other _____

Genital and Urinary Systems
Kidney Stones
Frequent Urinary Tract Infections
Genital Herpes or Other_____
Other _____

Musculoskeletal/Pain
Osteoarthritis

Gout

Chronic Pain
Other_____

Women's Health
(*Men – proceed to next section*)
How old were you when you had your first period?_____
When did your last period start?_____
How many times have you been pregnant?_____
Number of live births _____
Number of living children_____
If you've been pregnant, please check if you had any of the following
Gestational Diabetes (baby over 8 pounds)
Postpartum Depression
If you're still menstruating how long is your cycle?_____
Do you have any of the following?
Painful Periods
Heavy Periods
PMS
Frequent Yeast Infections
Hot Flashes
Mood Swings
Concentration/Memory Problems
Vaginal Dryness
Decreased Libido
Fibrocystic Breast Disease
Endometriosis
Fibroids

When was your last mammogram?____Within normal limits?___ Abnormal?___
When was your last pelvic exam/pap?____Within normal limits?__Abnormal?___

Men's Health
(*Women – proceed to next section*)

Please check if you have any of the following
Change in Libido
Difficulty Getting an Erection
Difficulty Maintaining an Erection
Prostate Enlargement
Nocturia (Urination During Night)
Number of Times/Night?_____
Urinary Urgency
Urinary Hesitance
Change in Urinary Stream

Relationships
Please rate on a scale of 5 (very well) to 1 (very poorly):

How well would you say things have been going for you

At your school or job _____
With your friends_____
With your significant other_____
With your sex life_____
With your children_____
With your parents_____
With your attitude_____
Overall _____

Psychological

Do you feel significantly less vital than you did a year ago?
Yes
No

Do you like the work you do?
Yes
No

Do you spend the majority of your time and money to fulfil responsibilities and obligations?
Yes
No

Have you ever sought counseling?
Yes
No

Are you currently in counseling?
Yes – What Kind?_____
No

Are you having a difficult time managing the stress in your life?
Yes
No

About how many hours do you sleep per night?_____

Do you have trouble falling asleep?
Yes
No

Do you have trouble staying asleep?
Yes
No

Do you take anything to help you sleep?
Yes
No

Do you snore?
Yes
No

Do you feel rested upon awakening?
Yes
No

Readiness

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to
Significantly modify your diet _____
Take several nutritional supplements each day_____
Modify your lifestyle (e.i, work demands, sleep habits)_____
Practice a relaxation technique _____
Engage in regular exercise_____

Have periodic lab tests to assess your progress_____

How supportive do you think those in your household will be to you making these changes?

Very
Sort of
Unsure

Other notes:

_____
_____
_____