

Integrative Medical Associates

1750 Randall Road, Suite 250

Elgin, IL 60123

MEDICAL HISTORY

All information contained within is strictly confidential according to HIPAA standards. Please print and complete all information.

Last Name _____ First Name _____ Middle _____

Address _____

City _____ State _____ Zip _____

Birth Date _____ Referred by _____

Home# _____ Cell# _____ Work# _____

Social Security Number _____

E-mail address _____ Visit us online at www.integrativemed.com

Marital Status _____ Employer* _____

Person responsible for the bill* _____ Relationship* _____

Responsible party's DOB* _____ Responsible party's Employer* _____

Insurance type _____ ID/Policy# _____ Group# _____

Person to notify in case of an emergency _____ # _____

Today's Date _____

Reason for seeing us today? _____

Last physical examination date _____

Symptoms/Problems:

Concisely list your symptoms/problems, i.e.: Why you are here today? What is bothering you? Explain if there is a pattern to the symptoms. Date symptoms/problems first recognized by patient. Score them 1-5. 1 = least bothersome, 5 = most bothersome.

Medications

A. List any medications, their specific names, dosage, and how often currently taken. (show brand names)

B. List any vitamin, mineral or nutritional supplements, their specific names, dosage, and how often currently taken. (show brand names)'

Do you take any of these daily or as often as 1-2 times a week?	Yes	No
Aspirin or Acetaminophen (Datril, Tylenol, Etc.)		
Ibuprofen (Advil, Nuprin)		
Sinus or allergy medications		
Laxatives		
Antacids		
Nose drops/sprays		
Ointments		
Antidepressants		
Nebulizers		
Other drugs		

Have you ever taken an oral cortisone preparation such as Prednisone, Decadron, Medrol or other?

Yes

No

Don't Know

About a week			
About two months			
About a month or more			

List any medications to which you are allergic or which cause unpleasant side effects. Please describe reaction:

Have you received cortisone type "allergy shots" such as Depo Medrol, Decadron, Kenalog, or others?

Yes No Don't Know

one _____

two _____

three _____

four _____

Have you ever been on birth control pills?

Are you taking them now?

Yes, but less than six months _____

Yes _____

Six months to two years _____

No _____

More than two years _____

Any side effects? _____

The approximate total amount of time that you have been on Tetracycline, Ampicillin, Keflex, Ceclor, Erythromycin, or other antibiotics (for any reason)

One month or less _____

One month to six months _____

Six months to two years _____

Two years or longer _____

The medical reasons for which you have taken the antibiotics listed above include (select all applicable):

Acne or other skin infection _____

Ear infections _____

Kidney, bladder, prostate, or other urinary tract infections _____

Tonsillitis _____

Strep Throat _____

"Colds" _____

Surgically related problems _____

Have symptoms occurred in the following patterns in the past year?

Worse outdoors _____

Improved outdoors _____

Increase in symptoms within 30 minutes after going to bed _____

Symptoms recur or increase with return of cold weather _____

Nasal symptoms with little or no itching of eyes_____

Worse in air conditioning_____ Symptoms increase in cooling evening air_____

Symptoms increase or occur while dusting or sweeping_____

Symptoms are worse outdoors 4:30-8:30p.m._____

Symptoms are worse in damp places_____ Worse September to heavy frost_____

Worse raking leaves or playing in leaves_____ Itching of the whole eye_____

Nasal symptoms without eye itching while mowing grass or playing on lawn_____

Symptoms increase around October 1st_____ Worse outdoors 7-11:00a.m._____

Runny nose, sneezing, eye or nose itching_____ Symptoms worse on clear days_____

Itching of the inside corners of the eye only_____ Little or no symptoms when it is raining_____

Improved indoors, especially in air conditioning_____ Worse in basements_____

Flare when going from air conditioned room to open air_____ Symptoms are worse in barns_____

Symptoms are worse around feed mills_____

Symptoms are worse in certain homes_____ Who's home?_____

React to cats or in home with cats_____ React to dogs or in home with dogs_____

React to other animals_____ Which?_____

Do you usually have ANY symptoms to ANY degree in these months?

January_____ February_____ March_____ April_____ May_____ June_____
July_____ August_____ September_____ October_____ November_____
December_____

What 2 consecutive months are your symptoms least bothersome?_____

What 2 consecutive months are your symptoms most bothersome?_____

Home Environment

Do you live in a house (if yes, how old?), apartment, mobile home?_____

Is it: In a wooded area or on a farm?_____

Is the garage: Attached, detached, breezeway?_____

Is the basement: Dry, damp, musty, ever flooded?_____

Is there a crawl space?_____

How long have you lived in your present home? _____

Have there ever been any animals in your home? _____

Have the pets been treated for fleas? _____ Did this cause any symptoms? _____

List current pets _____

How long have they been present? _____

Any insulating done? _____ Type _____ Year _____

Humidifier: On furnace _____ Room unit _____

Air purifier: Brand _____ What rooms _____

Smoking: Patient _____ Spouse _____ Mother _____ Father _____

Have you stopped smoking? _____ When? _____ Any symptoms after _____
What? _____

Type of drinking water: Well _____ City _____ Other _____

Type of floors in home: Hardwood _____ Plywood _____ Carpet _____

Any room in which symptoms are worse _____ Which? _____

List any new furnishings: _____ List any rooms with new carpet _____

List Gas or Electric: Stove _____ Water heater _____ Clothes dryer _____

What is your heating system: _____

Have you been away from your home or your environment in the last several years? _____

Where? _____ When away, were there any changes in your symptoms? _____

To what degree? _____

Work Environment

At work, are your symptoms: Better _____ Worse _____ The same _____

Any rooms at work where you are bothered: _____

Have you been exposed to any of the following items currently or previously at your job:
asbestos _____ chemicals _____ fumes _____ mists (like spray paints)

Biologics (blood, serum, etc.) _____ dusts (grain, cotton) _____ agricultural sprays _____

Do you think work and/or machines have anything to do with your symptoms?_____ If yes, please describe these materials and/or machines/equipment_____

Other Environmental

Do you notice an increase in symptoms in:

Church_____ Malls or shopping centers_____ School_____ Particular classroom_____
Car_____ Gas Station_____ Beauty parlor/hair stylist_____ Fabric store_____ Carpeting
store_____ Hospital_____ Other (what)_____

Do these products bother you?

Gasoline products_____ Exhaust fumes_____ Soaps/detergents_____ Fabric softeners_____
Bleaches_____ Chlorinated water_____ Ammonia_____ Polishes/floor waxes_____ Insect
sprays_____ Mosquito spray_____ Moth balls_____ Asphalt/tar_____ Disinfectant
sprays/liquids_____ Rubber products_____ Varnish, paint, shellac_____ Hair sprays_____
Cosmetics_____ Perfumes_____ Newsprint_____ Tobacco smoke_____ Metals (Nickel,
Mercury, Inexpensive earrings)_____ Other_____

If yes to any of these, what are your symptoms?

WEATHER:

Worse with storm front_____ Worse with wind_____ Worse on rainy days_____ Worse on
dry days_____ Other_____

FOODS:

Are you on any special diets at the present time: Rotation_____ Vegetarian_____ Low
salt_____ Pritikin_____ Weight reduction_____ Low cholesterol_____
Diabetic/Hypoglycemic_____ Stone age diet_____ Other_____

Are you excessively sleepy after meals?_____

Do you notice itching: Of the roof of the mouth_____ Between the shoulder blades_____
Inside the ear canal_____ And/or rash inside the bend of the elbows or behind the knees_____
Of the rectum_____ Of the nose_____

Do you get hives?_____ Do you get canker sores?_____

Have a foul breath odor?_____ Do you retaste foods after you have eaten
them?_____ Which foods?_____

Are you bothered by: Belching_____ Gas_____ Stomach ache_____ Nausea_____ Vomiting_____ Bloating_____ Constipation_____ Diarrhea_____

Do you notice increased symptoms 5-60 minutes after meals?_____

Do you awaken from sleep between 1am to 5am?_____ If yes, is there any specific food you are hungry for at that time?_____

Please list:

Any foods you avoid. Why you avoid them. _____

Any foods you eat excessively. I.e. once daily or more often. _____

What food you would miss most of taken out of your diet. _____

Alcohol beverages you drink and how often. _____

CANDIDA:

On antibiotics, frequently in past?_____ How long ago?_____ List any side effects (example: diarrhea)_____

Frequent vaginal infections, yeast infections, or infection of the prostate gland?_____

When on antibiotics, is there an increase in vaginal or prostate symptoms?_____

Do you have: Frequent fungal infections of nails?_____ Other fungal infections?_____

Thrush?_____ Ringworm?_____ Jock itch?_____ Athlete's foot?_____ Other skin signs?_____ Cracked or split nails?_____ Fingertips?_____ Cuticles?_____ Callouses?_____

Do you crave: Sugar_____ Breads_____ Pastries_____

Do you have symptoms when you drink alcoholic beverages?_____ What symptoms?_____

Are you bothered by premenstrual syndrome?_____ If yes, how does it bother you?_____

Have you ever had allergy testing done for airborne inhalants?_____ If yes, what type of testing and when was the testing done?_____

Are you taking allergy injections now?_____ If yes, how often?_____

How long have you been receiving allergy injections?_____

Date of last shot _____ Did you see improvement with the shots? _____

Have you ever been tested for food allergies? _____ If yes, what type of testing, when was the testing done, and what type of treatment did you receive after testing? _____

Can you have a good nights rest, wake up in the morning and still feel tired? _____

Do you have problems with short term memory? _____

Do you have greater emotional swings than what you think you should? _____

Do you not tolerate the cold? i.e.(Do you need to wear more clothes than others in order to stay warm?) _____

Do you think your reflexes(your neuromuscular responses) are as quick as the used to be/should be? Please explain. _____

Are you gaining more weight than you think you should for your calorie intake? _____

Please indicate if you, or anyone in your family, has/had any of the following. i.e. (yourself, spouse, mother, father, brother(s)/sister(s). Allergies _____ Asthma _____
Birth defects _____ Blood diseases (anemia, hemophilia, etc.) _____
Bone or joint disorders _____ Cancers, tumors, malignancies _____ Chronic lung diseases (asthma, TB, etc.) _____ Eye or ear disorders _____ Glandular diseases (thyroid, diabetes, etc.) _____ Heart trouble _____ Kidney or urinary disease (bladder problems, cystitis) _____ Mental retardation _____ Muscle disease (weakness, poor control) _____ Nerve disease (epilepsy, cerebral palsy, others) _____ Psychiatric condition _____ Vaginal discharge, yeast infection _____ Venereal disease (S.T.D.) _____ HIV positive— AIDS _____ High blood pressure _____ Gastro-intestinal disorders (ulcers, diverticulitis, Crohn's disease, irritable bowel syndrome, colitis) _____ Skin disorders (eczema, psoriasis, rashes) _____ Liver disease (hepatitis, cirrhosis, jaundice) _____ Mononucleosis _____ Polio myelitis _____ Cocksackie virus _____ Herpes _____ Migraine headaches _____ Alcoholism _____ Other _____

Comments: _____

Have you ever been hospitalized for any medical illness or operation? If yes, please write down your most recent hospitalizations: _____

Outpatient surgeries: _____

Please indicate whether or not you have had the following. If yes, please give year and results.

Chest X-ray _____

Kidney X-ray _____

G.I. series _____

Colon X-ray (barium enema) _____

Gallbladder X-ray _____

EKG _____

EEG _____

Immunoglobulins _____

Any other studies _____

Chicken pox _____

Mumps _____

Hepatitis _____

Croup _____

Chronic bronchitis _____

Measles _____

German measles (3 day) _____

Rheumatic fever _____

Whooping cough _____

Have you ever received a blood transfusion? If yes, when? _____

Have you been outside the continental U.S. in the past 5 years? If yes, where? _____

Overall Health Review:

Do you get headaches? _____ Age onset? _____ Duration? _____

How many days per month do you have headaches? _____

Do they interfere with sleep? _____ Do you have to go to sleep for the headache

to go away? _____ What type of headaches do you get? Pulsating _____

Constant _____ Severe _____ Migraine _____ Relieved by aspirin? _____ Relieved by

other _____

Aggravated by: Cigarettes _____ Cold drinks _____ Beer or liquor _____

Food _____ Other _____

Frequency: Regular _____ Periodic _____ Related to menstrual cycle _____

Time of year: Anytime _____ Fall _____ Spring _____ Summer _____ Winter _____

Daytime _____ Night time _____

Do you have any of the following? : Fainting _____ Depression _____ Mood swings _____

Hyperactivity _____ Irritability _____ Hallucinations _____ Forgetfulness/poor memory _____

Spacey feeling _____ Poor concentration _____ Apathy _____ Confusion _____ Seizures _____

Jekyll and Hyde Personality _____ Panic disorder _____ Sleep apnea _____ Insomnia _____

Nightmares _____ Sleepiness _____ Feelings of rage _____ Learning disorders _____ Numbness

or tingling _____ Anxiety (panic) _____ Dizziness _____ Listlessness _____ Fatigue (on arising,
after meals, or all the time?) _____

EYES: Itching _____ Burning _____ Pain _____ Tearing _____ Redness _____ Sensitivity to
light _____ Puffiness _____ Dark circles _____ Visual difficulties _____

Other _____

EARS: Itching _____ Full, blocked, or ear pressure _____ Frequent ear infections _____

Recurrent fluid behind eardrums _____ Redness _____ Aches _____ Sensitivity to sound _____

Hearing loss _____ Dizziness _____ Other _____

NOSE: Sneezing spells _____ Itching _____ Stuffiness _____ Runny nose _____ Post nasal

drip _____ Sinusitis _____ Sinus pressure/pain _____ Nosebleeds _____ Nasal polyps _____

Rubbing nose _____ Snoring _____ Other _____

THROAT: Itching _____ Soreness _____ Tightening _____ Swelling _____ Difficulty

swallowing _____ Choking _____ Hoarse voice _____ Frequent clearing of throat _____ Post-

nasal drainage _____ Other _____

MOUTH/TEETH/GUMS: Increased salivation _____ Bad breath _____ Dental problems

(explain) _____ Problem with anesthetic _____ T.M.J. _____ Coated

tongue _____ Canker sores _____ Gum disease _____ Tongue or lip swelling _____ Other _____

BREATHING: Coughing _____ Wheezing(with infection) _____ Wheezing(other times) _____

Chest to feel tight _____ Not enough air _____ Rapid breathing _____ Shortness of breath _____

Other _____ How many pillows do you sleep with? _____

Is your appetite: Good _____ Poor _____ Selective _____

Do you ever have: Stomach aches _____ Cramps _____ Intestinal gas _____ Inordinate

hunger/thirst _____ Nausea _____ Vomiting _____ Fullness/bloating _____ Constipation _____

Diarrhea _____ Foul odor (stool) _____ Other _____

Do you ever have: Rapid or irregular pulse _____ Heart murmur _____ Chest pains _____
Rheumatic fever _____ Other heart disease _____ Sweating _____ Chilly feeling _____ Puffy
face _____ Cold hands/feet _____ Other _____

Do you bruise: Spontaneously _____ Easily _____ Often _____ Other _____
Is your blood pressure: High _____ Low _____ Normal _____ Varies _____ Other _____

SKIN: Flush _____ Pallor-white _____ Acne _____ Dryness _____ Oiliness _____ Dandruff _____
Athlete's foot _____ Itching _____ Sores, infections _____ Vitiligo _____ Rashes _____ Excessive
or offensive body odor _____ Other _____ Please explain _____

MUSCLES/JOINTS: Arthritis _____ Bursitis _____ Fibrositis _____ Weakness _____
Shakiness _____ Aching or pain in: Neck _____ Upper back _____ Lower back _____ Legs _____
Is the aching/pain: Seasonal _____ Continuous _____ Other _____
Is any of this joined with swelling? If yes, please explain. _____

KIDNEY/BLADDER(urination): Painful _____ Delayed _____ Prolonged _____ Frequency of
daytime _____ Frequency of night time _____ Urgency _____ Bed wetting _____ Leaking of
urine _____ Frequent bladder infections _____ Other _____

PENILE/VAGINAL ORGANS: Sores _____ Itching _____ Yeast infections _____ Menstrual
irregularities _____ Pre-menstrual syndrome _____ Impotence _____ Loss of libido _____
Discharge _____ Please describe _____

SWELLING: Generalized _____ Hands _____ Fingers _____ Ankles _____ Intermittent _____
Continuous _____ Other _____

LYMPH: Swollen or tender glands _____ Other _____

STRESS: Home-Mild _____ Moderate _____ Severe _____

Work-Mild _____ Moderate _____ Severe _____

School-Mild _____ Moderate _____ Severe _____

Do you live near high tension lines? _____ Do you live close to a freeway? _____

Do you travel by air frequently? (12 or more times a year) _____

Do you exercise daily? _____ 3 or more times a week? _____ Is your car less
than 2 years old? _____ List the primary and secondary industries in your area _____

Parents, please fill out this page for information on your child.

Adults, please fill out this page for your infancy, if the information is available to you.

Patient's birth history:

During the pregnancy with patient, did mother have: High blood pressure _____ Diabetes or sugar in her urine _____ Albumin or protein in her urine _____ Urinary infection _____ German (3 day) measles _____ Take medicines prescribed by her doctor _____ Frequently smoke cigarettes. If yes, about how many? _____
Venereal disease (ex: Gonorrhea or syphilis) _____ Dependency on drugs or alcoholic beverages. If yes, please explain. _____
How long was the pregnancy? _____ How early did mother start seeing a doctor? _____
Did patient have hiccups while in mom's uterus? _____ Was this patient premature? _____
Was more than one baby born? _____ Did mother have a difficult delivery? _____ Was it a breech (bottom first) delivery? _____ Was it a cesarean delivery? _____ what was the patient's weight at birth? _____ Was there an Rh problem? _____ Was anything wrong with the patient at birth? If yes, please explain. _____

Maternal and family history of patient:

How many children have you (mother) had? _____ Which one is this child? _____ Have you (mother) had any premature births? _____ Have you (mother) had any cesarean births? _____
Have you (mother) had any miscarriages? _____ Mother's age now _____ Father's age now _____
Mother's height _____ Father's height _____ Number of people living in child's home _____ Who spends most of the time caring for child (father, mother, etc.)? _____

Introduction of foods:

Was this patient breast or bottle fed? _____ Failure to gain or excessive weight gain? _____
If bottle fed, what formula did you use? _____ Did you need to switch formulas for any reason? If yes, list formulas tried and reasons for changing each formula. _____

At what age did the patient begin solid foods? _____

Did patient have any problems with any solid foods introduced? If yes, list the foods and the problems noticed. _____

List any foods omitted from the diet during early childhood or infancy and why? _____

