

THE HAVERFORD WELLNESS CENTER

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CONFIDENTIAL HEALTH QUESTIONNAIRE

(PLEASE FAX OR MAIL TO OUR CLINIC BEFORE YOUR APPOINTMENT)

Today's Date _____ Soc. Sec. No. _____

Name _____ Date of Birth _____

Spouse's Name OR Parent's Names (if patient is a child) _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax _____ Email _____

Emergency Contact _____ Phone _____

MEDICAL HISTORY

List the main problems that you are having - current medical problems/date started

List Known Allergies to medication and type of reactions to:

List Current Medications / Drugs / Hormones and Amount Taking (not nutrients)

LAST NAME: _____

FIRST NAME: _____

MIDDLEINITIAL: _____

PATIENT'S NAME: _____

Date of Birth: _____

Height: _____ Weight: _____ Blood Type: _____

Clinical Hx And Presentation

Diagnosis:

Chief Complaint: _____

Presenting Symptoms: _____

Significant Medical Hx: _____

Allergies: (Check all that apply) _____

- Beef Cheese Chocolate Citrus Corn Eggs Milk Mold Peanuts Oat Pork Shellfish Wheat Chemical Sensitivity Universal Reactor

Diet Hx: (Check all that apply)

- | | | | | | |
|---------------------------------------|--|--|--|--|---|
| <input type="checkbox"/> Low Fat | <input type="checkbox"/> Vegetarian Diet | <input type="checkbox"/> Gluten Free Diet | <input type="checkbox"/> Diet Soda | <input type="checkbox"/> High Juice Intake | <input type="checkbox"/> Crave Bacon & Lunch Meat |
| <input type="checkbox"/> Low Carb | <input type="checkbox"/> Rotation Diet | <input type="checkbox"/> Generally Good Diet | <input type="checkbox"/> Nutrasweet | <input type="checkbox"/> Love ice cream | <input type="checkbox"/> Love Donuts |
| <input type="checkbox"/> High Carb | <input type="checkbox"/> No Meat Diet | <input type="checkbox"/> Allergy Free Diet | <input type="checkbox"/> High Caffeine | <input type="checkbox"/> Love milk | <input type="checkbox"/> High Sugar Intake |
| <input type="checkbox"/> Zone Diet | <input type="checkbox"/> High Fat Diet | <input type="checkbox"/> Milk/Casein Free Diet | <input type="checkbox"/> Enteral Feed | <input type="checkbox"/> Restrict Salt | <input type="checkbox"/> Crave Non-edibles |
| <input type="checkbox"/> EPD Diet | <input type="checkbox"/> Always Dieting | <input type="checkbox"/> High Bread/Pasta Diet | <input type="checkbox"/> Poor Food Choices | <input type="checkbox"/> Avoid Butter | <input type="checkbox"/> Avoid Eating |
| <input type="checkbox"/> Low Protein | <input type="checkbox"/> Ketogenic Diet | <input type="checkbox"/> Atkins Diet | <input type="checkbox"/> High Beef Diet | <input type="checkbox"/> Avoid Vegetables | <input type="checkbox"/> Over consumption of food |
| <input type="checkbox"/> High Protein | <input type="checkbox"/> Wheat Free Diet | <input type="checkbox"/> Heavy Alcohol | <input type="checkbox"/> French Fries | <input type="checkbox"/> Avoid Salads | <input type="checkbox"/> Microwave used |

Dietary Intake: (Circle Low (L), Medium (M), or High (H) intake For only those that pertain!

- | | | | | | |
|---------------|-------|----------------|-------|----------------|-------|
| Sesame Oil | L M H | MCT Oil | L M H | Lard | L M H |
| Safflower Oil | L M H | Soy Oil | L M H | Crisco | L M H |
| Flax Oil | L M H | Cottonseed Oil | L M H | Salad Dressing | L M H |
| Sunflower Oil | L M H | Peanut Oil | L M H | Mayonnaise | L M H |
| Walnut Oil | L M H | Corn Oil | L M H | Margarine | L M H |
| Olive Oil | L M H | Mineral Oil | L M H | Butter | L M H |
| Canola Oil | L M H | Mustard Oil | L M H | Coconut Butter | L M H |

Brand Names Used:

- Wesson
- Best Foods
- Hellmann's
- Miracle Whip
- Kraft
- Mazola
- Other _____

Fluid Intake: _____ Cups of Water _____ Cups of Juice _____ Cups of Milk _____ Cans of Soda _____ Cups of Coffee/Tea

Present Supplements: (Check all that apply)

- | | | | | | | | |
|--|-------------------------------------|----------------------------------|--------------------------------------|--------------------------------------|------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Acidophilus | <input type="checkbox"/> Buffered C | <input type="checkbox"/> Choline | <input type="checkbox"/> Omega Brite | <input type="checkbox"/> HCL | <input type="checkbox"/> MCT Oil | <input type="checkbox"/> Niacin | <input type="checkbox"/> Vitamin B12 |
| <input type="checkbox"/> B Complex | <input type="checkbox"/> Calcium | <input type="checkbox"/> CoQ10 | <input type="checkbox"/> Enzymes | <input type="checkbox"/> Iron | <input type="checkbox"/> MSM | <input type="checkbox"/> Primrose Oil | <input type="checkbox"/> Vitamin C |
| <input type="checkbox"/> Black Currant | <input type="checkbox"/> Carnitine | <input type="checkbox"/> DHA | <input type="checkbox"/> Fish Oil | <input type="checkbox"/> Lipoic Acid | <input type="checkbox"/> Multi Min | <input type="checkbox"/> Pyridoxine | <input type="checkbox"/> Vitamin E |
| <input type="checkbox"/> Borage Oil | <input type="checkbox"/> Chlorella | <input type="checkbox"/> DHEA | <input type="checkbox"/> Flax Oil | <input type="checkbox"/> Magnesium | <input type="checkbox"/> Multi Vit | <input type="checkbox"/> Vitamin A | <input type="checkbox"/> Zinc |

Quantity: Flax Oil per day _____ Fish Oil per day _____ DHA per Day _____ Max EPA per day _____ Other _____

Other Supplements: _____

Present Meds: (Check all that apply)

- | | | | | | | | |
|--|--|------------------------------------|------------------------------------|---|--|--|---------------------------------------|
| <input type="checkbox"/> Albuterol | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Cortisone | <input type="checkbox"/> DMPS | <input type="checkbox"/> Klonopin | <input type="checkbox"/> Nizoral | <input type="checkbox"/> Prozac | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Allopurinol | <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Depakote | <input type="checkbox"/> Enalapril | <input type="checkbox"/> Lamotrigine | <input type="checkbox"/> NSAIDs | <input type="checkbox"/> Risperdal | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Analgesics | <input type="checkbox"/> Beta Blockers | <input type="checkbox"/> Diflucan | <input type="checkbox"/> Estrogen | <input type="checkbox"/> Lasix | <input type="checkbox"/> Nystatin | <input type="checkbox"/> Ritalin | <input type="checkbox"/> Warfarin |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Blood Pressure Meds | <input type="checkbox"/> Digitalis | <input type="checkbox"/> HRT | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Phenobarbital | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Xanax |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Clozapem | <input type="checkbox"/> Dilantin | <input type="checkbox"/> Heparin | <input type="checkbox"/> Lithium | <input type="checkbox"/> Prednisone | <input type="checkbox"/> Synthroid | <input type="checkbox"/> Zoloft |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Clozapine | <input type="checkbox"/> Diuretics | <input type="checkbox"/> Inderal | <input type="checkbox"/> MAO Inhibitors | <input type="checkbox"/> Premarin | <input type="checkbox"/> Tegretol | <input type="checkbox"/> Lipitor |
| <input type="checkbox"/> Armour Thyroid | <input type="checkbox"/> Codeine | <input type="checkbox"/> DMSA | <input type="checkbox"/> Insulin | <input type="checkbox"/> Mevacor | <input type="checkbox"/> Provera | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Street Drugs |

Other Meds: _____

Review of Systems: (Check all that apply)

Skin:

- Acne Dry Liver Spots Rash White Bumps Ridged Nails
- Athlete's Foot Eczema Oily Redness White Patches Spoon Shaped Nails
- Bruising Hair Loss Pale Rough Yellow Tone White Spots on Nails
- Burning Feet Herpes Peeling Skin Tags Bluish Lips
- Cracks Hives Poor Wound Healing Vitiligo Deep Red Lips
- Dandruff Itching Psoriasis Warts Pale Lips

Eyes:

- Bags Under Cataracts Diplopia Floaters Light Sensitive Sclera blue Swollen Lids
- Blurred Vision Crusty Lids Discharge Freq. Blinking Pain Sclera White Tearing
- Burning Dark Circles Dyslexia Glaucoma Bloodshot Styes

Ears:

- Discharge Excessive Wax Infection Red Ear Lobes Sound Sensitive Vertigo
- Ear aches Hearing Loss Itching Ringing Tinnitus Pressure

Nose & Sinuses:

- Crusts Freq. Colds Itching Nose Bleeds Sinus Trouble Stuffiness
- Discharge Hayfever Mucus Yellow Polyps Sneezing Asthma HX

Mouth & Throat:

- Amalgams Canker Sores Silver Fillings Gag Easily Grind Teeth Lines on Tongue Mouth Ulcers
- Bad Breath Chapped Lips Dentures Gingivitis Hoarseness Lips Crack Red Tip Tongue
- Bleeding Gums Coated Tongue Drooling Glossy Tongue Implants Magenta Tongue Root Canals
- Bridges Crowns Freq Sore Throats Gold Fillings Infections Metal Braces Sore Tongue

Respiratory:

- Apnea Bronchitis Cough Pleurisy Shortness in Breath Smoke: Y or N Packs per Day _____
- Asthma Congestion Difficulty Breathing Pneumonia Wheeze

Cardiac:

- Cold Extremities Dyspnea Flushing of Skin High B/P Palpitations Atherosclerosis: Y/N _____
- Chest Pain Edema Heart Murmur Low B/P Tight Chest HX of Heart Surgery _____

Gastrointestinal:

- Abdominal Pain Bloating Diarrhea Gall Bladder Removed Ingestion Nausea Ulcers
- Anal Itching Colitis Difficulty Swallowing Heartburn Irritable Bowel Regurgitation Vomiting
- Belching Constipation Flatulence Hemorrhoids Mucus Tan Stool Fat intolerance

Urinary:

- Burning Frequency Incontinence Kidney Disease Polyuria Urgency Dark Yellow Urine
- Cystitis Hesitancy Infections Nocturia Stones Pale Urine

Genital (male):

- Discharge Impotence Itching Prostatic Hypertrophy Testicular Pain
- Genital Herpes Infertility Painful Urination Sores Infection

Genital (female):

- Birth Control Pills Endometriosis Genital Herpes Infertility Menopausal Symptoms Tender Breasts
- Discharge Excess Hair Growth Hot Flashes Irregular Cycle PMS Yeast Infections
- Dysmenorrhea Low Libido Hysterectomy Itching Spotting Excess Bleeding

Musculoskeletal:

- Arthritis CP Hx of Fractures Joint Swelling Muscle Weakness Spasticity
- Atrophy Fibromyalgia Hypotonia Limited Range/Motion Rigidity Stiffness
- Backache Gout Joint Pain Muscle Pain Spasms Uneven Muscular Development

Neurologic:

- Abnormal Gait Confusion Headaches Learning Problems Poor Dream Recall Shaky Feeling Unprovoked Anger
- ADD Delusional Hyperactivity Mood Swings Poor Memory Speech Delay Weakness
- ADHD Depression Impulsiveness Nervousness Rage Behavior Tension Withdrawal
- Anxiety Disoriented Insomnia Nightmares Restlessness Tics Autistic Features
- Apathy Excessive Sleepiness Irritable Numbness Sciatica Tingling Fasciculation
- Brain Fog Fainting Poor Coordination PDD Seizures Tremors Unable to Walk

Endocrine:

- Coarse Features Edema Excessive Thirst HRT Hypothyroid Underweight
- Cold Intolerance Excessive Hunger Fatigue Hyperthyroid Poor Carb Tolerance Diabetes Hx
- Dysinsulism Excessive Swelling Heat Intolerance Hypoglycemia Overweight

Immune:

- Autoimmune Cancer Hx Hepatitis Hx Lupus Recurrent Illness Blood Transfusion
- Breast Implants Chronic Fatigue Infection Lyme Hx Swollen Glands
- Allergic to everything CFS Hx Chemical Intolerance Dental Implants Universal Reactor

Please indicate past or present amounts:

	Daily	Weekly	Occasionally	Never	Past
Coffee/caffeine					
Tobacco (___ packs/day)					
Alcohol					
Aspirin					
Laxatives					
Exercise					
Meditation					

Date of last complete checkup _____ Results _____

Names of recent Doctors consulted _____

Are you willing to change your lifestyle/habits to improve your health? Yes No

Have you had adjustments or other treatments for your neck or back? Yes No

Do you follow a special diet? Yes No Organic certified? Yes No

Do you react to pollen? Yes No Reaction _____

Do you react to foods? Yes No Reaction _____

List any chemicals, metals, dusts, molds, or fumes to which you are repeatedly exposed: _____

Do you know your blood type? (Circle One) O A B AB (Circle One) Positive or Negative

Does your spiritual life play an important role in your life? Yes No

First Partnered _____ Number of years _____ Divorced/separated _____ When _____

Number of children _____ Ages/Gender _____

WOMEN ONLY

Number of children _____ Ages/Gender _____ Adopted _____

Number of: Pregnancies _____ Deliveries _____ Miscarriages _____ Abortions _____

Do you use a contraceptive? Yes No If so, what type _____

Last PAP smear _____ Result _____ Last mammogram _____ Result _____

Have you had a scan DEXA for bone density? Yes No Result _____

Are you taking hormone replacement therapy? Yes No What form? _____

FAMILY HISTORY

If family members have any of the following please identify which by the following:
 (Mother=M, Father=F, Brother=B, Sister=S, Grandparent=G, Child=C, Aunt=A, Uncle=U)

- | | | |
|--------------------------|----------------------------|------------------------------|
| 1. ___ Allergies | 7. ___ Stroke | 13. ___ Cancer |
| 2. ___ Alcoholism | 8. ___ High blood pressure | Type/s _____ |
| 3. ___ Asthma | 9. ___ Hypoglycemia | 14. ___ Kidney disease |
| 4. ___ Bleeding Disorder | 10. ___ Diabetes | 15. ___ Psychiatric disorder |
| 5. ___ Epilepsy | 11. ___ Neurologic disease | 16. ___ Lung disease |
| 6. ___ Heart Disease | 12. ___ Tuberculosis | 17. ___ Other _____ |

Do you have any of the above? Yes No If so which _____

Check if you have ever had any of the following.

- | | | |
|-----------------------------|------------------------------------|-------------------------------|
| 1. ___ Cataracts | 6. ___ Loss of libido or sex drive | 11. ___ Liver disease |
| 2. ___ Back Problems | 7. ___ Ulcers | 12. ___ Herpes |
| 3. ___ Gall bladder Trouble | 8. ___ Rheumatic fever | 13. ___ Lyme Disease |
| 4. ___ Seizures | 9. ___ Scarlet fever | 14. ___ Cancer: type of _____ |
| 5. ___ Insomnia | 10. ___ Thyroid disease | |

REVIEW OF SYSTEMS:

Please list any symptoms that you have now or experienced: (Please check past or present and how severe and frequent the problem-specify which by circling)

	Past	Present	How severe	How Frequent
1. Headaches	<input type="checkbox"/>	<input type="checkbox"/>		_____
2. Problems with vision, hearing, taste or smell	<input type="checkbox"/>	<input type="checkbox"/>		_____
3. Chest Pain or shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		_____
4. Cough, wheezing or other breathing difficulties	<input type="checkbox"/>	<input type="checkbox"/>		_____
5. Heartburn, gas, bloating, indigestion	<input type="checkbox"/>	<input type="checkbox"/>		_____
6. Constipation, diarrhea, hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>		_____
7. Urinary tract problems, stones, infections in the bladder or kidney	<input type="checkbox"/>	<input type="checkbox"/>		_____
8. Gynecologic problems(specify)	<input type="checkbox"/>	<input type="checkbox"/>		_____
9. Infertility, impotence, low libido	<input type="checkbox"/>	<input type="checkbox"/>		_____
10. Skin or hair problems	<input type="checkbox"/>	<input type="checkbox"/>		_____
11. Bone or joint disorders	<input type="checkbox"/>	<input type="checkbox"/>		_____
12. Neurological problems, Fasciculations	<input type="checkbox"/>	<input type="checkbox"/>		_____
13. Mood, emotion, or psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>		_____
14. Fatigue, night sweats, loss of motivation	<input type="checkbox"/>	<input type="checkbox"/>		_____

PATIENT'S NAME: _____

DIETARY HISTORY FORM

PLEASE FILL OUT THE FOLLOWING WITH WHAT YOUR DIET CONSISTS OF ON AN AVERAGE DAY. PLEASE BE AS SPECIFIC (AND HONEST) AS POSSIBLE!

BREAKFAST: _____

SNACK: _____

LUNCH: _____

SNACK: _____

DINNER: _____

SNACK: _____

PAST HISTORY

Please list all Accidents and Injuries:

Please List all Surgeries:

Please list all Countries you have Traveled to or Lived in the Past:

Where was your place of birth? _____

States where you lived in the past: _____

Do you see a dentist regularly? _____ Name of Dentist: _____

How many silver fillings did you have? _____ How many silver fillings do you have now? _____

How many root canals do you have? _____ Any tooth implants? _____

Have you had your fillings removed? _____ When? _____ Natural Dentist? _____

What is your primary source of water? (Circle One) Tap Well Bottled Filtered

How did you hear about us?

Do you have or have you had a toxic exposure such as mold in your home? Which one?

What are your goals to improve your health?

Thank you for taking the time to complete this form. It is the beginning of your process of healing and health.

Domenick Braccia, D.O.