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# Comprehensive Medical In-take Questionnaire
## Form 5 of 5

*Nutritional History, Lifestyle History, Social History*
*Readiness Assessment*

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# NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes ❑ No ❑

## FOOD DIARY

**Click** next to the food/drink that applies to your current diet.

| Usual Breakfast | Usual Lunch | Usual Dinner |
|---|---|---|
| ❑ None | ❑ None | ❑ None |
| ❑ Bacon/Sausage | ❑ Butter | ❑ Beans (legumes) |
| ❑ Bagel | ❑ Coffee | ❑ Brown rice |
| ❑ Butter | ❑ Eat in a cafeteria | ❑ Butter |
| ❑ Cereal | ❑ Eat in restaurant | ❑ Carrots |
| ❑ Coffee | ❑ Fish sandwich | ❑ Coffee |
| ❑ Donut | ❑ Fried foods | ❑ Fish |
| ❑ Eggs | ❑ Hamburger | ❑ Green vegetables |
| ❑ Fruit | ❑ Hot dogs | ❑ Juice |
| ❑ Juice | ❑ Juice | ❑ Margarine |
| ❑ Margarine | ❑ Leftovers | ❑ Milk |
| ❑ Milk | ❑ Lettuce | ❑ Pasta |
| ❑ Oat bran | ❑ Margarine | ❑ Potato |
| ❑ Sugar | ❑ Mayo | ❑ Poultry |
| ❑ Sweet roll | ❑ Meat sandwich | ❑ Red meat |
| ❑ Sweetener | ❑ Milk | ❑ Rice |
| ❑ Tea | ❑ Pizza | ❑ Salad |
| ❑ Toast | ❑ Potato chips | ❑ Salad dressing |
| ❑ Water | ❑ Salad | ❑ Soda |
| ❑ Wheat bran | ❑ Salad dressing | ❑ Sugar |
| ❑ Yogurt | ❑ Soda | ❑ Sweetener |
| ❑ Oat meal | ❑ Soup | ❑ Tea |
| ❑ Milk protein shake | ❑ Sugar | ❑ Vinegar |
| ❑ Slim fast | ❑ Sweetener | ❑ Water |
| ❑ Carnation shake | ❑ Tea | ❑ White rice |
| ❑ Soy protein | ❑ Tomato | ❑ Yellow vegetables |
| ❑ Whey protein | ❑ Vegetables | ❑ Other: (List below) |
| ❑ Rice protein | ❑ Water | |
| ❑ Other: (List below) | ❑ Yogurt | |
| | ❑ Slim fast | |
| | ❑ Carnation shake | |
| | ❑ Protein shake | |

How much of the following do you consume each week?

| TYPE OF FOOD | AMOUNT |
|---|---|
| Candy | |
| Cheese | |
| Chocolate | |
| Cups of coffee containing caffeine | |
| Cups of decaffeinated coffee or tea | |
| Cups of hot chocolate | |
| Cups of tea containing caffeine | |
| Diet soda | |
| Ice cream | |
| Salty foods | |
| Slices of white bread (rolls/bagels, etc) | |
| Soda with caffeine | |
| Soda without caffeine | |

Do you currently follow a special diet or nutritional program? Yes ❑ No ❑

- ❑ Ovo-lacto
- ❑ Diabetic
- ❑ Dairy restricted
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet

❑ Other (describe)_____

Please tell us if there is anything special about your diet that we should know.

_____

Do you have symptoms *immediately after* eating, such as belching, bloating, sneezing, hives, etc?
Yes ❑ No ❑

If yes, are these symptoms associated with any particular food or supplement? Yes ❑ No ❑
If yes, please name the food or supplement and symptom(s).

_____

Do you feel that you have *delayed* symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more) Yes ❑ No ❑

Do you feel **worse** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Does skipping meals greatly affect your symptoms? Yes ❑ No ❑

Has there ever been a food that you have craved or 'binged' on over a period of time? Yes ❑ No ❑

If yes, list craved/binged food(s):

_____

Do you have an aversion to certain foods? Yes ❑ No ❑

If yes, list aversion food(s):

_____

Please complete the following chart as it relates to your bowel movements:

| Frequency | √ |
|---|---|
| More than 3x/day | |
| 1-3x/ day | |
| 4-6x/week | |
| 2-3x/week | |
| 1 or fewer x/week | |

| Consistency | √ |
|---|---|
| Soft and well formed | |
| Often floats | |
| Difficult to pass | |
| Diarrhea | |
| Thin, long or narrow | |
| Small and hard | |
| Loose but not watery | |
| Alternating between hard and loose/watery | |

| Color | √ |
|---|---|
| Medium brown consistently | |
| Very dark or black | |
| Greenish color | |
| Blood is visible | |
| Varies a lot | |
| Dark brown consistently | |
| Yellow, light brown | |
| Greasy, shiny appearance | |

Intestinal gas:

❑ Daily ❑ Occasionally ❑ Excessive ❑ Present with pain ❑ Foul smelling ❑ Little odor

# LIFESTYLE HISTORY

## TOBACCO HISTORY

Have you ever used tobacco? Yes ❑ No ❑

If yes, what type?

❑ Cigarette ❑ Smokeless ❑ Cigar ❑ Pipe ❑ Patch/Gum How much?_____

Number of years?_____ If not a current user, year quit_____ Attempts to quit:_____

Are you exposed to 2nd hand smoke regularly? If yes, please explain:

## ALCOHOL INTAKE

Have you ever used alcohol? Yes ❑ No ❑

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes ❑ No ❑

Have you ever had a problem with alcohol? Yes ❑ No ❑

If yes, indicate time period (month/year) From_____to _____

## OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes ❑ No ❑

If yes, what type(s) and method? (IV, inhaled, smoked, etc)_____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes ❑ No ❑

If yes, indicate which

- ❑ Lead
- ❑ Arsenic
- ❑ Aluminum
- ❑ Cadmium
- ❑ Mercury

## SLEEP & REST HISTORY

Indicate average number of hours you sleep at night?

❑ More than 10 ❑ 8-10 ❑ 6-8 ❑ less than 6

Do you:

- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Have problems with insomnia?
- ❑ Snore?
- ❑ Use sleeping aids?

### EXERCISE HISTORY

Do you exercise regularly? Yes ❑ No ❑

| If yes, please indicate: | Times/week | | | | Length of session | | | |
|---|---|---|---|---|---|---|---|---|
| **Type of exercise** | 1x | 2x | 3x | 4x/+ | ≤15 | 16-30 min | 31-45 min | >45 |
| Jogging/Walking | | | | | | | | |
| Aerobics | | | | | | | | |
| Strength Training | | | | | | | | |
| Pilates/Yoga/Tai Chi | | | | | | | | |
| Sports (tennis, golf, water sports, etc) | | | | | | | | |
| Other (please indicate) | | | | | | | | |

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

_____

## SOCIAL HISTORY

Because stress has a direct effect on your overall health and well-being that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

### STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes ❑ No ❑

Do you feel you can easily handle the stress in your life? Yes ❑ No ❑

If no, do you believe that stress is presently reducing the quality of your life? Yes ❑ No ❑

If yes, do you believe that you know the source of your stress? Yes ❑ No ❑

If yes, what do you believe it to be?_____

Have you ever contemplated suicide? Yes ❑ No ❑

If yes, how often?_____When was the last time?_____

Have you ever sought help through counseling? Yes ❑ No ❑

If yes, what type? (e.g., pastor, psychologist, etc)_____

Did it help?_____

How well have things been going for you?

| | Very well | Fine | Poorly | Very poorly | Does not apply |
|---|---|---|---|---|---|
| At school | | | | | |
| In your job | | | | | |
| In your social life | | | | | |
| With close friends | | | | | |
| With sex | | | | | |
| With your attitude | | | | | |
| With your boyfriend/girlfriend | | | | | |
| With your children | | | | | |
| With your parents | | | | | |
| With your spouse | | | | | |

Which of the following provide you emotional support? *Check all that apply*

❑ Spouse ❑ Family ❑ Friends ❑ Religious/Spiritual ❑ Pets ❑ Other_____

Have you ever been involved in abusive relationships in your life? Yes ❑ No ❑

Have you ever been abused, a victim of a crime or experienced a significant trauma? Yes ❑ No ❑

Did you feel safe growing up? Yes ❑ No ❑

Was alcoholism or substance abuse present in your childhood home? Yes ❑ No ❑

Is alcoholism or substance abuse present in your relationships now? Yes ❑ No ❑

How important is religion (or spirituality) for you and your family's life?

❑ Not at all important ❑ Somewhat important ❑ Extremely important

Do you practice meditation or relaxation techniques? Yes ❑ No ❑

If yes, How often?_____

Check all that apply:

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai-Chi ❑ Prayer ❑ Other_____

Hobbies and leisure activities:

_____

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here?

Yes ❑ No ❑

## READINESS ASSESSMENT

*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 | 5_____ 4_____3_____2_____1_____ |
| Take nutritional supplements each day | 5_____ 4_____3_____2_____1_____ |
| Keep a record of everything you eat each day | 5_____ 4_____3_____2_____1_____ |
| Modify your lifestyle (e.g. work demands, sleep habits) | 5_____ 4_____3_____2_____1_____ |
| Practice relaxation techniques | 5_____ 4_____3_____2_____1_____ |
| Engage in regular exercise | 5_____ 4_____3_____2_____1_____ |
| Have periodic lab tests to assess progress | 5_____ 4_____3_____2_____1_____ |

Additional Comments:

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and well being.
Please fax the completed forms to 888-972-3985 or email as attachment to info@doctordonato.com.

Sincerely,
*Dr. Miven Donato*