SUSAN SAMUELI CENTER FOR INTEGRATIVE MEDICINE
UCIRVINE
WELLNESS FROM KNOWLEDGE

ADULT MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

Medical Record _____

First Name: _____ Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: ____/____/____ Age: _____
month day year

Work Phone: (_____) _____-_____ e-mail: _____

Occupation: _____ City or town & country if not US

Referred by: _____ Height: ___′____″ Weight: _____ Sex:_____

Today's Date _____

1. Please check appropriate box (es):

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European ☐ Other

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister

   _____
   _____
   _____

4. Do you have any pets or farm animals? Yes☐ No☐
   If yes, where do they live? 1. ☐ indoors 2. ☐ outdoors 3. ☐ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes☐ No☐
   If so, when and where? _____
   _____

6. Have you or your family recently experienced any major life changes? Yes☐ No☐
   If yes, please comment: _____
   _____

7. Have you experienced any major losses in life? Yes☐ No☐
   If so, please comment: _____
   _____

8. How important is religion (or spirituality) for you and your family's life?
   a. ☐ not at all important
   b. ☐ somewhat important
   c. ☐ extremely important

9. How much time have you lost from work or school in the past year?
   a. ☐ 0-2 days
   b. ☐ 3 –14 days
   c. ☐ > 15 days

10. Previous jobs:
    _____
    _____

11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

    Please do your best to answer the following questions:
    a. Did you feel safe growing up?
    ☐ Yes ☐ No

    b. Have you been involved in abusive relationships in your life?
    ☐ Yes ☐ No

c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
☐ Yes ☐ No

d. Do you currently feel safe in your home?
☐ Yes ☐ No

e. Do you feel safe, respected and valued in your current relationship?
☐ Yes ☐ No

f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
☐ Yes ☐ No

g. Would you feel safer discussing any of these issues privately?
☐ Yes ☐ No

12. Past Medical and Surgical History:

	ILLNESSES	WHEN	COMMENTS
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn's Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		
	ILLNESSES	**WHEN**	**COMMENTS**
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		

y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		
	INJURIES	**WHEN**	**COMMENTS**
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Other (describe)		
	OPERATIONS	**WHEN**	**COMMENTS**
au.	Appendectomy		
av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

13. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

14. How often have you have taken antibiotics?

	< 5 times	> 5 times
Infancy/ Childhood	☐	☐
Teen	☐	☐
Adulthood	☐	☐

15. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	> 5 times
Infancy/ Childhood	☐	☐
Teen	☐	☐
Adulthood	☐	☐

16. What medications are you taking now? Include non-prescription drugs.

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Are you Allergic to any medications? Yes☐ No☐

If yes, please list and indicate type of reaction:

Medication Reaction

17. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

18. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?	☐	☐	☐	
a. A preemie?	☐	☐	☐	
b. Breast fed?	☐	☐	☐	
c. Bottle fed?	☐	☐	☐	
2. As a child did you eat a lot of sugar and/or candy?	☐	☐	☐	

19. As a child, were there any foods that you had to avoid because they gave you symptoms?
Yes ☐ No ☐
If yes, please: name the food and symptom (Example: milk – gas and diarrhea)
_____
_____
_____

20. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
a.	None	☐	a.	None	☐	a.	None	☐
b.	Bacon/Sausage	☐	b.	Butter	☐	b.	Beans (legumes)	☐
c.	Bagel	☐	c.	Coffee	☐	c.	Brown rice	☐
d.	Butter	☐	d.	Eat in a cafeteria	☐	d.	Butter	☐
e.	Cereal	☐	e.	Eat in restaurant	☐	e.	Carrots	☐
f.	Coffee	☐	f.	Fish sandwich	☐	f.	Coffee	☐
g.	Donut	☐	g.	Juice	☐	g.	Fish	☐
h.	Eggs	☐	h.	Leftovers	☐	h.	Green vegetables	☐
i.	Fruit	☐	i.	Lettuce	☐	i.	Juice	☐
j.	Juice	☐	j.	Margarine	☐	j.	Margarine	☐
k.	Margarine	☐	k.	Mayo	☐	k.	Milk	☐

l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
	Usual Breakfast	√		**Usual Lunch**	√		**Usual Dinner**	√
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

21. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

22. Are you on a special diet? Yes☐ No☐

☐ ovo-lacto ☐ vegetarian _____ other (describe):

☐ diabetic ☐ vegan _____

☐ dairy restricted ☐ blood type diet _____

23. Is there anything special about your diet that we should know? Yes☐ No☐
If yes, please explain:

_____

24. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.? Yes☐ No☐

b. If yes, are these symptoms associated with any particular food or supplement(s)? Yes☐ No☐

c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

_____

_____

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

26. Do you feel much **worse** when you eat a lot of :

☐ high fat foods
☐ high protein foods
☐ high carbohydrate foods (breads, pastas, potatoes)
☐ refined sugar (junk food)
☐ fried foods
☐ 1 or 2 alcoholic drinks
☐ other _____

27. Do you feel much **better** when you eat a lot of :

☐ high fat foods
☐ high protein foods
☐ high carbohydrate foods (breads, pastas, potatoes)
☐ refined sugar (junk food)
☐ fried foods
☐ 1 or 2 alcoholic drinks
☐ other _____

28. Does skipping a meal greatly affect your symptoms? Yes☐ No☐

29. Have you ever had a food that you craved or really "binged" on over a period of time?
Food craving may be an indicator that you may be allergic to that food. Yes☐ No☐
If yes, what food(s)? _____

_____

30. Do you have an aversion to certain foods? Yes☐ No☐
If yes, what foods? _____

31. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

32. Intestinal gas:
- ☐ Daily
- ☐ Occasionally
- ☐ Excessive
- ☐ Present with pain
- ☐ Foul smelling
- ☐ Little odor

33. a. Have you ever used alcohol? Yes ☐ No ☐
b. If yes, how often do you now drink alcohol?
- ☐ No longer drinking alcohol
- ☐ Average 1-3 drinks per week
- ☐ Average 4-6 drinks per week
- ☐ Average 7-10 drinks per week
- ☐ Average >10 drinks per week

c. Have you ever had a problem with alcohol? Yes ☐ No ☐
If yes, please indicate time period (month/year): from _____ to _____.

34. Have you ever used recreational drugs? Yes ☐ No ☐

35. Have you ever used tobacco? Yes ☐ No ☐
If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
If yes, what type of nicotine have you used?
- ☐ Cigarette
- ☐ Smokeless
- ☐ Cigar
- ☐ Pipe
- ☐ Patch/Gum

36. Are you exposed to second hand smoke regularly? Yes ☐ No ☐

37. Do you have mercury amalgam fillings? Yes ☐ No ☐

38. Do you have any artificial joints or implants? Yes ☐ No ☐

39. Do you feel worse at certain times of the year? Yes ☐ No ☐
If yes, when?
- ☐ spring
- ☐ summer
- ☐ fall
- ☐ winter

40. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes ☐ No ☐
If yes, which one(s)?
- ☐ lead
- ☐ arsenic
- ☐ aluminum
- ☐ cadmium
- ☐ mercury

41. Do odors affect you? Yes ☐ No ☐

42. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school	☐	☐	☐	☐	☐
b. In your job	☐	☐	☐	☐	☐
c. In your social life	☐	☐	☐	☐	☐
d. With close friends	☐	☐	☐	☐	☐
e. With sex	☐	☐	☐	☐	☐
f. With your attitude	☐	☐	☐	☐	☐
g. With your boyfriend/girlfriend	☐	☐	☐	☐	☐

h.	With your children																				
i.	With your parents																				
j.	With your spouse																				

43. Have you ever had psychotherapy or counseling? Yes ☐ No ☐
Currently? _____ Previously? _____ If previously, from _____ to _____.
What kind? _____
Comments: _____

44. Are you currently, or have you ever been, married? Yes ☐ No ☐
If so, when were you married? _____ Spouse's occupation _____
When were you separated? _____ Never ☐
When were you divorced? _____ Never ☐
When were you remarried? _____ Never ☐ Spouse's occupation _____
Comments: _____

45. Hobbies and leisure activities: _____
_____

46. Do you exercise regularly? Yes ☐ No ☐

If so, how many times a week?
1. ☐ 1x
2. ☐ 2x
3. ☐ 3x
4. ☐ 4x or more

When you exercise, how long is each session?
1. ☐ ≤15 min
2. ☐ 16-30 min
3. ☐ 31-45 min
4. ☐ > 45 min

What type of exercise is it?
☐ jogging/walking
☐ basketball
☐ home aerobics
☐ tennis
☐ water sports
☐ other _____