INITIAL HEALTH SURVEY FOR MEN

Please answer all questions. If not applicable, write "NA". Please return to:

Francis Holistic Medical Center, P.C.
360 West Boylston Street, Suite 107
West Boylston, Massachusetts 01583
(508) 854-1380 Fax: (508) 854-0446

PLEASE COMPLETE ALL INFORMATION, IF POSSIBLE.

Name: _____ Date of Initial Visit: _____
Address: _____
_____
Home Phone: _____ Birthday: _____ Age: _____ Sex: _____
Driver's License #: _____ Business Phone: _____
Occupation: _____Employer: _____
Work Address: _____
_____
Insurance Company: _____ Social Security #: _____
Education: Number of years completed: _____ Religion: _____
Marital Status: _____ Household Members & Ages: _____
_____
Spouse's Name: _____ Spouse's Occupation: _____
Spouse's Employer: _____ Spouse's Business Phone: _____
Names and complete addresses of other physicians: _____
_____
_____
_____
Names, Addresses, and Phone Numbers of nearest living relatives:
_____ Relationship: _____
_____ Relationship: _____
In emergency, notify:
_____ Phone: _____
Please specify who referred you to this office. (Circle Source)
Family Friend School Physician Clergy Court Self Other:
Name: _____ Phone: _____
Address: _____

THIS QUESTIONNAIRE MAY OR MAY NOT APPEAR TO RELATE TO YOUR REASON FOR COMING TO THIS OFFICE. PLEASE ANSWER THE QUESTIONS THAT DO APPLY TO YOU AS COMPLETELY AS POSSIBLE. MANY TIMES, PROBLEMS ARE MORE COMPLEX THAN THEY SEEM AT FIRST, AND YOUR ANSWERS WILL HELP US EVALUATE YOU MORE COMPLETELY.

THANK YOU.
CmM-Qst-3Mel (Bl)

I. CHIEF COMPLAINT AND PRESENT ILLNESS

Chief Complaint (main symptom): _____
_____

When did it begin and how has it progressed? _____
_____
_____
_____
_____
_____
_____

What treatment have you had and by whom? _____
_____
_____
_____

When and where did you have your last complete physical? _____
What were the results? _____

List current medical problems. List past medical problems.

_____ _____
_____ _____
_____ _____

What do you want to achieve with your first visit to the office? _____
_____
_____
_____

Check if you have ever had:	When?	Childhood Illnesses:
_____ Lapse of consciousness	_____	_____
_____ Convulsions	_____	_____
_____ History of allergy	_____	_____
_____ Stroke	_____	_____
_____ High blood pressure	_____	Hospitalizations:
_____ Heart attack	_____	(when, where, why?)
_____ Diabetes	_____	_____
_____ Arthritis	_____	_____
_____ Emphysema	_____	_____
_____ Pneumonia	_____	_____

PLEASE LEAVE THIS SPACE FOR OFFICE USE ONLY:

II. DRUG HISTORY

What drugs do you take on a regular basis? What strength and how much?

_____

_____

List any drugs or injections that caused a reaction and list the symptoms caused.

Drug	Symptom	Drug	Symptom
_____		_____	
_____		_____	
_____		_____	

Have you ever reacted to: Dental anesthetics _____ Tetanus antitoxin _____
Tetanus Toxoid _____ Iodides _____ X-ray contrast media _____
Penicillin _____ Other _____ If so, what? _____

If you have had any of the following tests place an (X) in the appropriate box, and if you can, give the year you last had them.

Year	Test	Year	Test
_____	( ) Chest X-ray	_____	( ) Gallbladder X-ray
_____	( ) Kidney X-ray	_____	( ) Electrocardiogram
_____	( ) G.I. Series	_____	( ) T.B. Tests
_____	( ) Colon X-ray		

III. MEDICAL HISTORY

Please indicate the severity of each symptom by placing a number from 1 to 10, with 10 being the most severe, in the blank. Judge the severity by the frequency and intensity of the symptom; 10 is considered almost unbearable. Leave blank if not applicable.

A. Skin

Indicate also any past or current skin symptoms with P (for past), C (for current), or I (for intermittent).

_____ Shingles	_____ Itching	_____ Bruising
_____ Cracking	_____ Fungus	_____ Rash
_____ Edema	_____ Brittle nails	_____ Boil
_____ Blanching	_____ Oiliness	_____ Scalp problems

Has your skin ever been bothered by contact with any substances? _____
If yes, which substances? _____

B. Headaches and Cerebral

What type and intensity of pain do you experience?

_____ Constant _____ Constriction _____ Excruciating _____ Episodic

Severity: _____ Please grade from 0-10.

Where is your head pain and how does it come and go?

_____ Lasts seconds, minutes, hours, days	_____ Returns regularly
_____ Upper teeth	_____ Back of the eye
_____ Worse lying down	_____ Clears without treatment

With what is your headache associated?

_____ Tearing/swelling of eye _____ Inflamed eye
_____ Visual disturbance _____ Nausea
_____ Nasal blockage/running _____ Neck/shoulder pain
_____ Abdominal pain

Are your headaches preceded or worsened by:

_____ Humidity _____ Intense light _____ Eye strain _____ Noise
_____ Odors _____ Muscle strain _____ Anxiety
_____ Motions/infections _____ Arguments _____ Overheating
_____ Foods

When does your headache usually occur?

_____ When lying down _____ Spring _____Summer
_____ Fall _____ Winter

At what age did headache first occur? _____

Check all that applies to you:

_____ Can keep working _____ Require eye covering
_____ Cannot keep working _____ Require bed rest
_____ Require hospitalization _____ Pressure to head

Have you ever had:

_____ A head injury _____ Encephalitis _____ When?

Do you know any causes of your headaches?

_____ Yes _____ No If yes, please explain _____

What medications and how much of each do you take daily for headache? _____
_____

C. Eyes

Give a number for the severity (1 – 10) of the symptom. Leave blank if not applicable. Indicate every symptom you have if your eyes trouble you.

_____ Styes _____ Blurred/double vision
_____ Irritated _____ Crusting lids
_____ Mucus in eyes _____ Puffy under eyes
_____ Twitching lids _____ Dark circles
_____ Swelling both lids _____ Sensitive to light
_____ Glaucoma _____ Cataracts/see halos
_____ Wear contacts/glasses
_____ Pain

Are your eye symptoms present all year round? _____ Yes _____ No

Which is your worst season? _____

D. Ears

Please indicate every symptom that applies to your ears with a number from 1 to 10 to indicate the severity. Leave blank if not applicable.

_____ Hearing loss _____ Frequent infections
_____ Fluid in ears or draining in ears _____ Dizziness
_____ Pain/pressure/stuffed up _____ Crusting inside

_____ Itching inside _____ Ringing/roaring
_____ Other

E. Nose
Please indicate the severity from 1 – 10. Leave blank if not applicable.
_____ Itches _____ Bleeds _____ Sinus infections
_____ Blocks _____ Post nasal drip _____ Require nose drops/spray
_____ Sneeze _____ Runs _____ No sense of smell
_____ Polyps _____ Other
Are these symptoms present all during the year? _____ Yes _____ No
Which is your worst season? _____
Indicate when symptoms are worse:
_____ Upon arising _____ After meals _____ After medicines
_____ Upon lying down _____ Cold weather _____ Dry weather
_____ Hot weather _____ Humid weather _____ Other

F. Mouth and Throat
Please indicate severity from 1- 10. Leave blank if not applicable.
_____ Snore _____ Sleep mouth open _____ Difficulty swallowing
_____ Hoarse _____ Canker sores _____ Cracking lips/corners
_____ Bad breath _____ Tongue swollen _____ Throat itches
_____ Bad taste _____ Throat clearing _____ Neck glands swell
_____ Lips swell _____ Wear dentures _____ Grind teeth in sleep
_____ Chapped lips _____ Fever blisters _____ Throat closed
_____ Sore throat/tongue _____ Lose voice _____ Other

G. Cardiac and Respiratory
Please indicate the severity from 1 –10 of every symptom that applies. Indicate any symptoms with P (for past), C (for current), or I (for intermittent) after the listed symptom. Otherwise, leave blank.
_____ Wheeze _____ Coughs _____ Frequent infections
_____ Frequent colds _____ Croup _____ Tight/heavy chest
_____ Ankle swelling _____ Short of breath _____ Heart enlargement
_____ Murmurs _____ Irregular heart beats _____ Night sweats
_____ Chest pain _____ Other _____ Pneumonia(__Times)
What is your main symptom? _____
Indicate when this symptom is worse:
_____ Morning _____ Afternoon _____ Evening
_____ Spring _____ Summer _____ Fall
_____ Winter _____ Year round _____ Other
Which medications relieve you best? _____
How soon? _____ For how long? _____
How far can you walk vigorously before becoming short of breath?_____
Maximum weight: _____ Minimum weight: _____ Desired weight:_____
Do you smoke? _____ Did you ever smoke? _____ Packs per day?_____
When did you stop? _____

Do you exercise regularly? _____ Type of exercise: _____
How often do you exercise? _____
Do you consider yourself to be under (low, moderate, high) levels of stress?

H. Gastrointestinal/Digestive

Indicate the severity, from 1 – 10, of each symptom that applies to you. Indicate any symptoms with P (for past), C (for current), or I (for intermittent) after the listed symptom. Otherwise, leave blank.

_____ Intestinal gas
_____ Indigestion
_____ Bloody/tarry stools
_____ Anal itching/pain
_____ Re-taste food
_____ On special diet
_____ Ulcer
_____ Burning stomach relieved by eating
_____ Stool/foul odor
_____ Frequent nausea/vomiting
_____ Bloating
_____ Poor/good appetite
_____ Mucous in stool
_____ Diarrhea/constipation
_____ Gallbladder trouble

I. Urinary and Genitalia

Indicate the severity, from 1 – 10, of each symptom that applies. Indicate every symptom with P (for past), C (for current), or I (for intermittent) after the listed symptom. Otherwise, leave blank.

_____ Frequent urination
_____ Itching
_____ Kidney disease
_____ Prostate trouble
_____ Had or have cancer
_____ Spouse being treated for infections
_____ Difficulty urinating
_____ Bladder disease
_____ Infections
_____ Lumps, pain swelling/testes
_____ Unsatisfactory sexual relations
_____ Bed wetting
_____ Weak stream
_____ Pass blood

J. Herpes History

Are you subject to: _____ Fever blisters (cold sores)
_____ Shingles
_____ Genital herpes

On what part of your body do they occur? _____
When did the attacks first begin? _____
How frequently do they occur? _____
How long do the attacks usually last? _____
Do the attacks follow any pattern of recurrence? _____
List the treatments you have used. _____

IV. PSYCHOLOGICAL HISTORY

Indicate severity, from 1 – 10, for every symptom that applies. Indicate any symptoms with P (for past), C (for current), and I (for intermittent). Leave blank if not applicable.

Symptom	When
_____ Often unhappy	_____

_____ Feel "lost in time" _____
_____ Incessant talker _____
_____ Am a workaholic _____
_____ Numbness _____
_____ Profuse sweating _____
_____ Hyperactive _____
_____ Go to pieces easily _____
_____ Sleep problems _____
_____ Unable to concentrate _____
_____ Have had visions _____
_____ Have heard voices _____
_____ Frustration/anger _____
_____ Loss of memory _____
_____ Irritable/aggressive _____
_____ Frequently keyed up or jittery _____
_____ Startled by sudden noises _____
_____ Considered a nervous person _____
_____ Extremely shy or sensitive _____
_____ Misunderstood by others _____
_____ Am being controlled by other forces _____
_____ Have seriously considered suicide _____
_____ Often unable to perform work _____
_____ Unable to coordinate muscles _____
_____ Feeling of hostility _____
_____ Been addicted to a drug _____
_____ Feel withdrawn _____
_____ Restless legs _____
_____ Often break out in cold sweats _____
_____ Feel groggy _____

Grade the extent to which you have these qualities. 0=None, 1=Slight, 2=Moderate, 3=Average, 4=Great

_____ Love _____ Joy _____ Peace _____ Patience
_____ Kindness _____ Gentleness _____ Faith _____ Self-control
_____ Trust _____ Strength

In what do you have faith? _____ Trust? _____
What is the source of your strength? _____
To what do you owe these qualities? _____

V. NUTRITIONAL HISTORY

Indicate the number of times consumed with x1, x2, etc., under the appropriate column. Use only one column for each food item and leave blank if the food is not consumed.

Food	**Daily**	**Weekly**	**Monthly**
Alcohol (type)			
Carbonated beverages			

Ice cream			
Candy			
Beef			
Bacon/sausage			
Butter (pat)			
Margarine (pat)			
Cold breakfast cereal			
Chicken			
Fish			
Raw fruit			
Bran			
Soy/tofu			
Rice			
Potato			
Tomato			
Green Vegetables			
Eggs (1)			
Yogurt (8.oz)			
Cheese (2 oz.)			
Pastries/cookies			
Catsup			
Honey (tbsp.)			
Sugar (tsp.)			
Coffee			
Tea, regular			
Tea, herbal			
Instant breakfast cereal			
Raw vegetables			
Salad			
Bread			
Milk			
Yellow vegetables			
Citrus			

Do you use: _____ Canned food _____ Salt _____ Fried food
_____ White bread
_____ Whole wheat or whole grains

Please indicate each heading below with 1 (for none), 2 (for moderate), or 3 (for a lot).

Eats excessively when bored or depressed _____
Gulps food _____
Fights weight gain _____
Eats foods the patient knows are “bad” for him/her _____
Eats “on the run” _____
Chews thoroughly _____
Reads and appreciates food labels _____

Do you prefer: _____ Beer _____ Scotch _____ Bourbon
_____ Wine _____ Gin _____ Vodka
_____ Rum _____ Variety

List all the foods you have ever avoided because they bother you.

_____

VI. FOOD HISTORY

Indicate the severity of each symptom, from 1 – 10. Otherwise, leave blank. Indicate any symptoms with P (for past), C (for current), or I (for intermittent) in the space after the symptom.

Do you have:

_____ Excessive hunger
_____ Excessive weight loss/gain
_____ Cook from "scratch"
_____ Use convenience food
_____ Eat "junk" food
_____ Other?
_____ Special diet
_____ Eat daytime/bedtime snacks
_____ Bothered by food odors
_____ Crave drinks/foods
_____ Use exotic foods

As an infant or child, did you ever have:

_____ Food/drink intolerance
_____ Mood disturbances
_____ Fussiness
_____ Constipation/diarrhea
_____ Skin rash
_____ Night sweats
_____ Learning problem
_____ Leg aches
_____ Poor appetite
_____ Wet the bed
_____ Failure to thrive
_____ Constant hunger
_____ Stomachaches/gassiness
_____ Other?

Is there a family history of allergies or food intolerance? _____

Are most of your meals: _____ At home _____ At restaurants
_____ Gourmet

Do you mostly eat foods that are: _____ Fresh _____ Canned
_____ Frozen _____ Packaged

What is your favorite or most enjoyed food and beverage? _____

_____

VII. MEDICAL HISTORY

Print the names of your relatives, living or deceased. Place an (X) in the appropriate column below for any illnesses that you or the relatives listed have had.

Father _____
Mother_____
Brother(s)/Sister(s) _____
_____
Children _____
_____

Grandparents _____

_____

	Yours	Your Father	Your Mother	Your Siblings	Your Children	Your Grandparents
Allergies						
Anemia						
Arthritis						
Asthma						
Bleeding						
Bruising						
Cancer						
Convulsions						
Diabetes						
Drinking						
Drug Problems						
Eczema						
Emphysema						
Heart Trouble						
Hepatitis						
High Blood Pressure						
Frequent Infections						
Kidney Problems						
Mental Illness						
Migraine						
Abnormal Periods						
Psoriasis						
Pneumonia						
Polio						
Prostate						
Rheumatic Fever						
Stomach Problems						
Stroke						
Thyroid Problems						

If appropriate, comment on any of the above.