Patient Medical History & Symptoms

Integrative Lyme Center of Rhode Island, LLC.

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All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name____________________________ ☐ M ☐ F D.O.B_________________

Address____
____

Home #__________________________ Alternate #____________________________

Email_________________________________

Occupation______________________ Highest Level Education___________________

Employer___________________________ Phone #____________________________

Address____
____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Separated

Spouse's Name____

Occupation___________________________ Phone #__________________________

Pharmacy____________________________ Phone #___________________________

As a courtesy to our allergy patients, please refrain from wearing perfume, cologne, or any scented deodorants, body oils/ lotions or hair products while visiting the office.

Thank you for your cooperation

35 South Angell Street, Providence, RI 02906 401.585.7877

Patient Medical History & Symptoms

History of present Illness

Please list the significant symptoms for which you are seeking help:

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Please provide a brief history of these problems and approximately how long have they been present?

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Patient Medical History & Symptoms

Have you received any treatment for the above problems? (If so, it would be helpful if you could list your physicians, their specialties, or treatment procedures.)

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Have you ever been hospitalized for any illness?

____ Date __________________

____ Date __________________

____ Date __________________

____ Date __________________

Are there any past medical problems for which you have been treated?

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Patient Medical History & Symptoms

Medications presently in use and / or treatment used in the past 6 months

- ☐ Antacid
- ☐ Antibiotic
- ☐ Antispasmodic
- ☐ Laxative / Cathartics
- ☐ Antihistamine
- ☐ Muscle Relaxant
- ☐ Tranquilizer
- ☐ Nasal Decongestion
- ☐ Pain / Analgesic
- ☐ Aspirin
- ☐ Anticonvulsant
- ☐ B12
- ☐ Steroids
- ☐ Sedative
- ☐ Sleeping pill
- ☐ Antidepressant
- ☐ Stimulant
- ☐ Diet / weight control
- ☐ Water pill/ Diuretics
- ☐ Heart Disease
- ☐ For Cholesterol
- ☐ For Cancer
- ☐ For Tuberculosis
- ☐ Cough / cold medication
- ☐ For Ulcers
- ☐ For Liver
- ☐ For Thyroid
- ☐ For Blood Pressure
- ☐ Cortisone
- ☐ Contraception pill
- ☐ Anti-inflammatory
- ☐ Hormone pill
- ☐ Asthma medication
- ☐ Potassium Chloride
- ☐ For Hypoglycemia
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Other

Vitamins and other supplements presently used and how often:

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Comments

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Patient Medical History & Symptoms

Father:	**Mother:**
If Deceased, age at death: ______________________	If Deceased, age at death: ______________________
Cause of Death: ________________________________	Cause of Death: ________________________________
Brother (s)	**Sister (s) :** ______________________________________
Ages____	Ages ____

Family Illnesses (P = Parent, GP = Grandparents, S = Sibling)

*Allergies*____	*Diabetes*____
*Psoriasis*_______________________________________	*Chronic Headaches*________________________________
*Eczema*____	*Severe migraine*__________________________________
*Bronchitis*______________________________________	*Drug Addiction*___________________________________
*Obesity*____	*Excessive medication*_______________________________
*Asthma*____	*Epilepsy*____
*Thyroid*____	*Violent episodes*__________________________________
☐ *High* ☐ *Low*	
Alcoholism______________________________________	*Arthritis*____
Stroke____	*Gout*____
Heart Attack_____________________________________	*Rheumatism*______________________________________
High blood pressure_______________________________	*Nervousness*_____________________________________
Ulcerative colitis__________________________________	*Depression*______________________________________
Chron's disease___________________________________	*Mental breakdown*__________________________________
	(with hospitalization)
Cancer____	*Schizophrenia*_____________________________________
Hypoglycemia_____________________________________	*Other*____

Patient Medical History & Symptoms

Psychological Stress Index

1. Frequently keyed up and jittery
   - ☐ Never ☐ Sometimes ☐ Always
2. Extremely shy or sensitive; uncomfortable with strangers or new situations
3. Misunderstood by other
   - ☐ Never ☐ Sometimes ☐ Always
4. Feelings of hostility and anger on many occasions.
   - ☐ Never ☐ Sometimes ☐ Always
5. Consistent irritability
   - ☐ Never ☐ Sometimes ☐ Always
6. Unable to perform work
   - ☐ At home ☐ On the job
7. Addiction difficulties
   - ☐ Illicit drugs ☐ Prescription Drugs ☐ Alcohol ☐ Food ☐ Past ☐ Present
8. Family difficulties
   - ☐ With spouse ☐ Parent ☐ Children ☐ Other__________________
   - ☐ Past ☐ Present ☐
9. Depression
   - ☐ Sadness ☐ Cry easily ☐ Disappointment ☐ Self blame ☐ Suicidal thoughts
   - ☐ Get up early, insomnia ☐ No appetite

Life Stress Index

1. Death of Spouse
   - ☐ Last 6 months ☐ Within lifetime ☐ In near future
2. Death of Child
   - ☐ Last 6 months ☐ Within lifetime ☐ In near future
3. Divorce
   - ☐ Last 6 months ☐ Within lifetime ☐ In near future
4. Jail
   - ☐ Last 6 months ☐ Within lifetime ☐ In near future
5. Death of family member or close friend
   - ☐ Last 6 months ☐ Within lifetime ☐ In near future
6. Personal injury
   - ☐ Last 6 months ☐ Within lifetime ☐ In near future
7. Marriage
   - ☐ Last 6 months ☐ Within lifetime ☐ In near future

8. Loss of employment
   - ☐ Last 6 months ☐ Within lifetime ☐ In near future
9. Pregnancy
   - ☐ Last 6 months ☐ Within lifetime ☐ In near future
10. Sexual difficulties
   - ☐ Last 6 months ☐ Within lifetime ☐ In near future
11. Financial loss/gain
   - ☐ Last 6 months ☐ Within lifetime ☐ In near future

Sleep

- ☐ Muscle Twitching
- ☐ Awake tired
- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Snoring
- ☐ Very Light
- ☐ Heavy
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Restless
- ☐ Disturbing Dreams
- ☐ Dreamless
- ☐ Frequent wakening
- ☐ Medication (s)

Energy

- ☐ Low ☐ Constant ☐ Intermittent
- ☐ High
- ☐ Exhaustion, not refreshed by sleep
  Fatigue ☐ during ☐ after exercise
- ☐ Listless mental / physical
- ☐ Lack of Drive ☐ Recent ☐ Always
- ☐ Listless ☐ during ☐ after exercise
- ☐ other_______________________________

Cravings

- ☐ Water
- ☐ Sweets / Chocolate
- ☐ Coffee or Tea
- ☐ Bread
- ☐ Alcohol
- ☐ Tobacco
- ☐ Salt
- ☐ Sugar
- ☐ Other
  ____

Patient Medical History & Symptoms

Favorite Foods

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Comments

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Smoking

☐ Yes How much? ___________________________________

☐ No

Alcohol

☐ Yes, How Frequent? ☐ Daily; quantity ______________________ ☐ Weekly

☐ Social (monthly or less) ☐ only with meals

☐ Only on weekends

☐ Wine ☐ Beer ☐ Spirits

☐ No

☐ Treatment for drinking problem ☐ Past ☐ Present

Comments

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____

____

Patient Medical History & Symptoms

Activity & Exercise

☐ Sedentary lifestyle
Describe ____

☐ Walking
Describe ____

☐ Gym
Describe ____

☐ Sports
Describe ____

Comments

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History of Weight Problem (record in space provided how long):

☐ Gain and / or loss (at least 3-4 lbs in one day)
☐ Weight control needed constantly
☐ Difficult to control despite calorie counting
☐ Compulsive eating (especially under emotionally stressful situations)
☐ Under weight always
☐ Overweight always (as child, adolescent, adult)
☐ Cholesterol problems, on medication
☐ Bulimia (secretive, had treatment)
☐ Anorexia (hospitalized)
☐ Fluid Retention
☐ Frequent Dieting
☐ Frequent snacking
☐ Other

Patient Medical History & Symptoms

Allergies:

- ☐ Animals
- ☐ Pollen
- ☐ Mold
- ☐ Aerosols
- ☐ Perfumes
- ☐ Air conditioning
- ☐ Auto exhaust
- ☐ Industrial chemicals
- ☐ Food
- ☐ Sugar
- ☐ Wine and alcohol
- ☐ food addictives
- ☐ Milk products
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Causing Asthma
- ☐ Allergic rhinitis
- ☐ Urticaria (hives)
- ☐ Conjunctivitis
- ☐ Other________________

Allergy Symptoms:

Have you been previously tested and treated? ____

Injections______________________________________For how long?_____________________________________

Physician ---------------------

Is your allergy condition ☐ Constant ☐ Seasonal ☐ Only indoors ☐ Only outdoors ☐ Both indoors & out ☐ Food related ☐ Immediately after meals ☐ Delayed up to 72 hours

Travel:

- ☐ Within USA & Canada
- ☐ Outside country
- ☐ Latin America / Mexico
- ☐ Far East
- ☐ Africa

Symptoms ☐ Fevers Parasites ☐ Diarrhea ☐ other

Patient Medical History & Symptoms

Headaches (record the length of time you have had these symptoms in the space provided)

Relieved by ☐ Aspirin ☐ Tylenol ☐ Advil ☐ Fiorinal

- ☐ Recurring
- ☐ Front headache
- ☐ Eyes ache
- ☐ Back of head and neck
- ☐ Migraine
- ☐ With nausea
- ☐ After stress (argument, etc)
- ☐ After food
- ☐ Temples ache
- ☐ Exposed to mold, pollens, chemicals

Hypothyroid Syndrome

- ☐ Increase in weight
- ☐ Decreased appetite
- ☐ Fatigue easily
- ☐ Ringing in ears
- ☐ Sleepy during day
- ☐ Sensitive to cold
- ☐ Dry or scaly skin
- ☐ Constipation
- ☐ Mental sluggishness
- ☐ Hair coarse, falls out
- ☐ Headaches upon arising, wear off during day
- ☐ Slow pulse, below 65
- ☐ Frequency of urination
- ☐ Impaired hearing
- ☐ Reduces initiative
- ☐ Failing memory

Hypoadrenal Syndrome

- ☐ Weakness, dizziness
- ☐ Chronic Fatigue
- ☐ Low blood pressure
- ☐ weak nails, ridges in nails
- ☐ Tendency for hives
- ☐ Arthritis Tendency
- ☐ Intestinal trouble
- ☐ Poor circulation
- ☐ Kidney trouble (edema)
- ☐ Salt craving
- ☐ Brown spots or skin bronzing
- ☐ Allergies, asthma tendencies
- ☐ Weakness after colds / flu
- ☐ Exhaustion muscular & nervous
- ☐ Respiratory Disorders
- ☐ Tired legs

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Hypoglycemia Syndrome

- ☐ Inward trembling
- ☐ Irritable before meals
- ☐ Sweating spells
- ☐ Craving for sweets
- ☐ Can not get startws in the morning
- ☐ Drink _____ cups of coffee daily
- ☐ Eat often or get hunger pains or faintness
- ☐ Eat when nervous
- ☐ Eating relieves fatigue and tiredness
- ☐ Faintness if meals delay
- ☐ Lack energy or energy drive
- ☐ Insomnia
- ☐ Moods of depression blues, melancholy
- ☐ Chronic fatigue
- ☐ Crave coffee or candy in the afternoon
- ☐ Cry easily for no reason
- ☐ Get shaky if hungry
- ☐ Heart palpitations
- ☐ Highly emotional
- ☐ Sleepy during the day
- ☐ Sleepy after meals

Candida Syndrome

- ☐ History of Antibiotics
- ☐ History of birth control pills
- ☐ History of steroids for asthma
- ☐ History of athlete's foot, ringworm
- ☐ Fatigue/lethargy
- ☐ Poor memory
- ☐ Spacey
- ☐ abdominal pain, contipation
- ☐ Bloating
- ☐ Prostatitis, impotence
- ☐ P.M.S.
- ☐ Endrometriosis
- ☐ Decreased sexual drive/desire
- ☐ Drowsiness
- ☐ Irritability, mood swings
- ☐ Headache
- ☐ Poor concentration
- ☐ Depression
- ☐ Vaginal discharge