Pacific Medical Group LLC

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Primary Care Medicine

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PATIENT INFORMATION

Name ____ Date ________________________

Sex _____ Marital Status _______ Date of Birth: _____________ Home Phone _____________________________

Address ___________________________________ City _______________________ State ______ Zip ___________

Occupation ____________________________________ Who referred you to our office? ________________________

Social Sec. # _______-_____-__________ Bus. Phone (_____) _____-________ Employer ________________________

What is your preferred contact phone number? Home Cellular Work

May the office staff leave a message, for you at this number? Yes No

EMERGENCY CONTACT: Name ___________________________________ Phone _____________________________

INSURANCE INFORMATION

Name of insured ______________________________________ Relationship to Patient ________________________

Insurance Co. Name ____ Phone # ____________________________

Insurance Co. Address___________________________________ City________________ State____ Zip ___________

Group/Member # ___________________________________ Employer # ___________________________________

How much is your deductible?____________ How much have you used?___________ Max. annual benefit?_________

HEALTH HISTORY & CURRENT STATUS

Medication/Supplement/Herbal/Vitamin History

What are your main health concerns at this time? Order by importance to you:
1.
2.
3.
4.

What would you like to get out of this consultation today?
1.
2.
3.

What do you think you need to heal?

Please rate your overall level of health: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)
Please rate your overall level of stress: (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Please assign a number value to your satisfaction with the following areas of your life; 1 is low & 10 is the highest:

Physical environment ________ Health ________ Fun & recreation ________
Romance/significant other ________ Career ________ Friends/family ________
Personal growth ________ Money ________

Personal Medical History

Allergies: list all known allergies to medications, environment and food AND reaction.
1.
2.
3.

Birth History: ❒ Premature ❒ Breathing problems ❒ Breech ❒ C-section ❒ Vaginal birth ❒ Time of day: ______________
Childhood health: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent) Place lived: ____
❒ Breastfed ❒ Formula ❒ Colic ❒ Illnesses: __________________________________ Received antibiotics? ❒ Yes ❒ No
Height: __________ Weight: _________ Weight 1 year ago: _________ Maximum weight: _________ Age at that time: _____
Is there any possibility that you are pregnant? ❒ Yes ❒ No

List all previous surgeries & year:	Describe all serious illnesses & year diagnosed:
1.	1.
2.	2.
3.	3.
4.	4.
List all accidents and injuries (if not listed above):	**List all hospitalizations:**
1.	1.
2.	2.
3.	3.
4.	4.

Have you been under the care of a licensed heath care professional in the past year? ❒ Yes ❒ No
If so, for what reasons? ____
Indicate dates for the most recent (if ever) of the following preventative exams. Write “never” if you’ve never had this test.

Physical exam: _______________ Eye exam: _______________ Prostate/Gyn exam: _____________
Full blood work: ______________ Dental exam: _____________ Mammogram: __________________
Colonoscopy: ________________ Fecal Occult Blood test: ____ Bone density: __________________

List immunizations: ____
Any reaction ever? ❒ No ❒ Yes: what happened? ____

Preferred pharmacy name/city: ____ Phone: ______________

Name	Dosage/Frequency	How long taken?	What for?	Who prescribed?

Family Medical History

List illnesses that have occurred in your blood relatives including: cancer, high blood pressure, heart disease, renal disease (kidneys), TB, bleeding tendencies, diabetes, stroke, mental disease, drug or alcohol addiction, glaucoma, psychiatric illness

Family Member	Current Age	Diagnosis	Age at diagnosis?	Current health or age at death
Father				
Mother				
Paternal g'father				
Paternal g'father				
Maternal g'father				
Maternal g'mother				
Sibling				
Sibling				
Sibling				
Sibling				
Children				
Children				
Children				

Dietary Habits

Please list typical foods consumed on a regular basis Do you have any routines around eating? ❒ Yes ❒ No ❒ Sometimes

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Fluids: ____

Any food cravings? Please list: ____

Check which foods/substances you use & describe what kind, how much & how many times a week:

❒ Caffeine	❒ Alcohol	❒ Candy/sweets
❒ Carbonated beverages	❒ Tobacco (with history & quit date)	❒ Margarine
❒ Milk/ ice cream		❒ Fast food
❒ Cheese	❒ Fried foods	❒ Luncheon meats

If you use alcohol: Have you ever felt you should cut down? ❒ Yes ❒ No

Have people ever been annoyed with you or nagged you about your drinking? ❒ Yes ❒ No

Have you ever felt guilty about your drinking? ❒ Yes ❒ no

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ❒ Yes ❒No

For the following questions, check all that apply to you:	
How Is Your Appetite?	❒ None ❒ Weak ❒ Normal ❒ Strong ❒ Irregular
How Does Food Affect You?	❒ Satisfied, Energized ❒ Unsatisfied, Still Hungry ❒ Fatigued, Sleepy
How Do You Eat?	❒ Sitting ❒ On The Go ❒ Snacking Throughout The Day
Temperature Preferences:	❒ Hot Food ❒ Cold Food ❒ Hot Drinks ❒ Cold Drinks ❒ Varies
Is Your Thirst:	❒ Extreme ❒ Changeable ❒ No Thirst ❒ Dry Mouth
Which Tastes Do You Prefer?	❒ Sweet ❒ Sour ❒ Salty ❒ Pungent ❒ Bitter ❒ Astringent
Do you follow a special diet?	Please describe &/or check all that apply: ______________________________ ❒ Non-Vegetarian ❒ Vegetarian ❒ Vegan ❒ Raw Foods ❒ Low Fat Diet ❒ Low carb ❒ No carb ❒ Paleo ❒ APOE gene diet ❒ Elimination diet ❒ GAPS/SCD
Eating disorders or other issues with eating?	❒ Current ❒ Past Please describe:
Any food reactions or intolerances?	Please describe:

How many glasses of water do you consume each week?_____

How many meals do you eat out per week? ___________

When I eat meat, fish or poultry:

- ❑ I almost always have it fried or cooked with oil or another fat, or with gravy
- ❑ I almost always have it broiled, baked or stewe and without any gravy or fat
- ❑ I do both
- ❑ I don't eat meat, fish or poultry

On average, how often do you eat breakfast in a week? ____

How often do you choose organic foods?

❒ Always ❒ Sometimes ❒ Never

When I eat cooked vegetables:

- ❑ I almost always have them with butter, margarine or sauce; or cooked with butter, magarine oil or another fat.
- ❑ I almost always have them without any of the fats listed above.
- ❑ I do both.
- ❑ I don't eat cooked vegetables

Please circle any digestive symptoms that you experience:			
Abdominal Pain	Bloating	Heartburn	Overweight
Acid Reflux	Candida	Hiccups	Sudden Weight Loss
Aggravated By Spices	Eating Disorder	Hypoglycemia	Ulcers
Bad Breath	Food Allergies	Nausea	Underweight
Belching	Gas	Nutritional Deficiencies	Vomiting

Please circle any elimination symptoms that you experience:			
Anal Fissures	Crohn's Disease	Incomplete Evacuation	Oily Stools
Anal Itching/Burning	Diarrhea	Intestinal Pain/Cramping	Parasites
Blood In Stools	Difficulty Passing Stools	Irritable Bowel Syndrome	Rectal Prolapse
Colitis	Gallstones	Laxative Use	Smelly Stools
Constipation	Hemorrhoids	Mucus In Stools	Undigested Food In Stools

Daily Schedule

	Time	Routine	Activity	Variation	Spritual Practices	Exercise
Morning						
Mid-morning						
Lunch						
Mid-Afternoon						
Evening						
Late-evening						
Middle of the night						
Sleep patterns:	Rate ease of falling asleep: (Easy) 1 2 3 4 5 6 7 8 9 10 (Difficult) Rate ease of staying asleep: (Easy) 1 2 3 4 5 6 7 8 9 10 (Difficult)					

Are you sexually active? ❒ Yes ❒ No Frequency? __________________ Current method of birth control? __________________

Have you ever contracted a sexually transmitted disease? ❒ Yes ❒ No If so, what & when?

____

Do you exercise regularly? ❒ Yes ❒ No Length of time? __________ Times per week? ______ Types ____________________

Body temperature: Do you generally run hot or cold? Please explain: ______________________________

Adrenal Health Quiz: Please check the appropriate box if you frequently or currently have the symptom mentioned.			
Headaches	❒ Yes ❒ No	Poor memory or concentration	❒ Yes ❒ No
Irritability	❒ Yes ❒ No	Bruise easily or find wounds heal slowly	❒ Yes ❒ No
Thyroid problems	❒ Yes ❒ No	Exercise more than one time each week	❒ Yes ❒ No
Palpitations	❒ Yes ❒ No	Need caffeine in the morning or after lunch	❒ Yes ❒ No
Allergies or asthma	❒ Yes ❒ No	Frequent/chronic infections	❒ Yes ❒ No
Dry, thinning skin	❒ Yes ❒ No	Energy is good all day	❒ Yes ❒ No
Unexplained hair loss	❒ Yes ❒ No	Low body temperature	❒ Yes ❒ No
Skip meals	❒ Yes ❒ No	**1 pt for each yes: TOTAL _____________**	

Emotionally over-stressed	❒ Yes ❒ No	Get light-headed when sitting or standing	❒ Yes ❒ No
Tenderness across lower back	❒ Yes ❒ No	"Second wind" (high energy) at bedtime	❒ Yes ❒ No
Depression or down moods	❒ Yes ❒ No	Chronic or recurrent inflammation	❒ Yes ❒ No
Low blood pressure	❒ Yes ❒ No	**3 pts for each yes: TOTAL ____________**	

Chronic pain	❒ Yes ❒ No	Symptoms of PMS ****See below**	❒ Yes ❒ No
Insomnia ***see below**	❒ Yes ❒ No	(breast tenderness, abdominal cramping, heavy periods, mood swings)	
Low blood sugar/hypoglycemia	❒ Yes ❒ No	Menopausal or perimenopausal ****See below**	❒ Yes ❒ No
(headaches, sleepy, mood swing if skipping meals)		(skipped periods, between 45-55 yrs old, hot flashes, vaginal dryness)	
		5 pts for each yes: TOTAL _____________	

Ultimate total of all 3 sections: _______________
If your score >10 you probably have some degree of adrenal dysfunction
If your score >20 it is highly probable that you have adrenal dysfunction
If your score >30 it is nearly certain that you have adrenal dysfunction

*** Insomnia: Complete if you experience insomnia**			
Difficulty falling asleep	❒ Yes ❒ No	>20 min to fall asleep once lights are off	❒ Yes ❒ No
Racing mind at time of sleep	❒ Yes ❒ No	Second wind (high energy) at night	❒ Yes ❒ No
Trouble staying asleep	❒ Yes ❒ No	Trouble going back to sleep once awakened	❒ Yes ❒ No
Wake more than once per night	❒ Yes ❒ No	Frequently awaken between 2-3 am	❒ Yes ❒ No
Recall your dreams	❒ Yes ❒ No	Experience restless legs when trying to sleep	❒ Yes ❒ No
Have vivid or disturbing nightmares	❒ Yes ❒ No	Sleep/nap during daylight hours	❒ Yes ❒ No
Snore	❒ Yes ❒ No	Feel groggy or sleepy when you awaken	❒ Yes ❒ No
Been diagnosed with sleep apnea	❒ Yes ❒ No	Work "third shift" (work nights/sleep days)	❒ Yes ❒ No
Exercise late in the day	❒ Yes ❒ No	Depressed when weather is cloudy/overcast	❒ Yes ❒ No
Eat carb snacks before bed?	❒ Yes ❒ No	Take sleeping pills (natural or prescription)	❒ Yes ❒ No
(cake, cookies, ice cream)		Use coffee, caffeine or other stims/meds?	❒ Yes ❒ No
Eat nothing b/n dinner & bedtime	❒ Yes ❒ No	Children or pets sleep in your room	❒ Yes ❒ No
Drink alcohol in evenings/nights	❒ Yes ❒ No	Sinus/ allergies/ asthma worse at night	❒ Yes ❒ No
Sleep partner keeps you awake due to	❒ Yes ❒ No	History of concussive injury/ head injury	❒ Yes ❒ No
Snoring or restlessness	❒ Yes ❒ No	Insomnia related to your menstrual cycle	❒ Yes ❒ No
Menopausal or have had hysterectomy	❒ Yes ❒ No	**Total "yes" answers _______________**	

****Pre & Peri Menopausal Women**			
Frequent/irregular periods	❒ Yes ❒ No	Moody or irritable during or before periods	❒ Yes ❒ No
Severe abdominal cramping w/ periods	❒ Yes ❒ No	Trouble sleeping due to racing mind/thoughts	❒ Yes ❒ No
Breast tenderness around periods	❒ Yes ❒ No	Trouble getting pregnant/ miscarriage(s)	❒ Yes ❒ No
History or current uterine fibroids	❒ Yes ❒ No	Anxiety or panic attacks	❒ Yes ❒ No
Depression or post-partum depression	❒ Yes ❒ No	Current/ past use (2 yrs) of birth control pills	❒ Yes ❒ No
Headaches/ migraines at time or period	❒ Yes ❒ No	History of no period for 3 months at a time	❒ Yes ❒ No
Cravings for sugar, fat, salt or chocolate	❒ Yes ❒ No	Bloating/ water retention with periods	❒ Yes ❒ No
Pain during intercourse	❒ Yes ❒ No	Family history of breast/ uterine/ ovarian cancer	❒ Yes ❒ No
endometriosis	❒ Yes ❒ No	**Total "yes" answers ________________**	

****Post-Menopausal Women**			
Hot flashes	❒ Yes ❒ No	Your last menstrual period was >1 yr ago	❒ Yes ❒ No
Severe sweating at night	❒ Yes ❒ No	Concern for osteoporosis or hip/spinal fracture	❒ Yes ❒ No
Vaginal dryness	❒ Yes ❒ No	Trouble sleeping due to mind racing/thoughts	❒ Yes ❒ No
Vaginal thinning	❒ Yes ❒ No	Get anxiety or panic attacks	❒ Yes ❒ No
Reduced libido	❒ Yes ❒ No	Family history of breast/ uterine// ovarian cancer	❒ Yes ❒ No
Pain during intercourse	❒ Yes ❒ No	Take hormone replacement (pills, cream, patches)	❒ Yes ❒ No
History of hysterectomy	❒ Yes ❒ No	**Total "yes" answers _________________**	❒ Yes ❒ No

Toxicity & Inflammation Scales

Please check mark if your work or home environment exposes you to the following:			
❒ Hazardous substances	❒ Stress	❒ Loud noise	❒ Carbon monoxide
❒ Structure built before 1975	❒ Mold	❒ Heavy lifting	❒ Born outside the U.S.
❒ Motor vehicle emissions	❒ Asbestos	❒ Air pollution	❒ Exposed to infectious person in last 2 weeks
❒ Second hand smoke	❒ Radiation	❒ Pesticides	❒ Eaten in a fast food restaurant in last 2 weeks
❒ Recent travel outside the U.S.	❒ Chemicals	❒ Sun & UV light	

This questionnaire gives an indication of your toxicity and inflammation levels based on common signs and symptoms. Periodically, you may be asked to submit this questionnaire again to examine progress during and after treatments.

Point scale:
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

Section	Symptoms	Section	Symptoms	Section	Symptoms
Head ____ Total	___ Headaches ___ Dizziness ___ Insomnia ___ Faintness	**Heart** ____ Total	___ Chest pain ___ Irregular or skipped heartbeat ___ Rapid or pounding heartbeat	**Energy Level** ____ Total	___ Fatigue/low energy ___ Restlessness ___ Hyperactivity ___ Crave certain foods
Ears ____ Total	___ Itchy ears ___ Ringing in ears or loss of hearing ___ Earaches/infections ___ Drainage from ear	**Lungs** ____ Total	___ Asthma, bronchitis ___ Chest congestion ___ Shortness of breath ___ Difficulty breathing	**Weight** ____ Total	___ Underweight ___ Overweight ___ Difficulty losing weight ___ Crave certain foods
Eyes ____ Total	___ Bags or dark circles under eyes ___ Watery or itchy eyes ___ Swollen/red/sticky eyelids ___ Blurred or tunnel vision (excluding near/far-sight)	**Skin** ____ Total	___ Acne or brown age or brown "liver" spots ___ Hives, rashes, cysts or boils ___ Eczema or psoriasis ___ itchy skin/dermatitis ___ hair loss, thinning ___ body odor ___ excessive sweating	**Other** ____ Total	___ PMS ___ Frequent colds, flu ___ Chemical or enviro-mental sensitivities ___ Food allergies/ sensitivities
Nose ____ Total	___ Stuffy nose ___ Sinus congestion/ infection ___ Constant sneezing ___ Hay fever/allergies ___ Excess mucus formation	**Joints/ Muscles** ____ Total	___ Pain or aches in joints or lower back ___ Stiffness or limitation of movement ___ Arthritis ___ Pain or aches in muscles		Please add the numbers from each section and write the section total in the spaces provided. Then add all the section totals together and put that total in the space below: __________ **Grand Total** Interpreting your Grand Total score: 15 or lower: Low toxicity level 16 – 49: Moderate toxicity level 50 or higher: High level of toxicity
Mouth Throat ____ Total	___ Chronic coughing ___ Sore throat/hoarseness loss of voice ___ Gagging, frequent need to clear throat ___ Swollen tongue, gums, lips ___ Swollen lymph nodes ___ Canker sores, mouth ulcers	**Mental/ Emotional** ____ Total	___ Poor memory ___ Difficulty concentrating ___ Mood swings ___ Depression ___ Anxiety, fear or nervousness ___ anger, irritability or aggressiveness ___ Insomnia		

Review of Systems

Check all the symptoms that are of concern to you at this time that you want to discuss with the practitioner. On the comments line, please indicate if any checked symptoms are *current* or *past* and describe any area in which you have experienced a severe episode and indicate if that episode was in previous 6 months or prior to 6 months ago.	
Head	❒ Headaches ❒ Dizziness ❒ Fainting spells ❒ Loss of balance ❒ Difficulty remembering ❒ Difficulty thinking clearly ❒ Thinning or loss of hair Comments:
Eyes	❒ Blurry ❒ Dry ❒ Tic/twitch ❒ Itchy ❒ Red ❒ Watery ❒ Cataracts ❒ Color blindness ❒ Burning ❒ Contacts/ glasses For ___ Years ❒ Farsighted ❒ Nearsighted ❒ Glaucoma ❒ Eye strain ❒ Mucus ❒ Night blindness ❒ Pain/soreness in eyes ❒ Poor/loss of vision ❒ Sensitive to light ❒ Floaters Comments:
Ears	❒ Earaches/pain ❒ Excess Earwax ❒ Hearing loss ❒ Ringing ❒ Sensitivity To Sound ❒ Discharge Comments:
Nose	❒ Loss of smell ❒ Bleeding ❒ Pain ❒ Discharge ❒ Post-nasal drip ❒ Sinus congestion ❒ Frequent Colds ❒ Nasal Polyps ❒ Deviated Septum Comments:
Mouth	❒ Excessive thirst ❒ Loss of taste ❒ Strange taste ❒ Bad breath ❒ Lip ulcers or lesions ❒ Dry/cracking lips ❒ Tongue pain ❒ Bleeding gums ❒ Receding gums ❒ Tooth pain ❒ Cavities ❒ Tooth sensitivity ❒TMJ ❒ Dry mouth ❒ Excess saliva Comments:
Throat/ Neck	❒ Pain ❒ Swollen glands ❒ Stiffness ❒ Lumps ❒ Difficulty Swallowing Comments:
Hair & Nails	❒ Dandruff ❒ Dry ❒ Hair Loss ❒ Oily ❒ Brittle, Break Easily ❒ Dry, Rough ❒ Ridged ❒ Oily ❒ Pale ❒ Pink ❒ Smooth Comments:
Skin	❒Acne ❒ Boils ❒ Bruises Easily ❒ Clammy ❒ Dry ❒ Eczema ❒ Fungal Infections ❒ Itching ❒ Psoriasis ❒ Rashes/Hives ❒ Scars ❒ Sensitive ❒ Skin Eruptions ❒ Changing or bleeding moles Comments:
Perspiration	❒ Spontaneous Or Without Exertion ❒ Excessive ❒ Rarely ❒ Nighttime ❒ Cold Sweats ❒ Unusual Odor Comments:
Respiration	❒ Asthma ❒ Bronchitis ❒ Cough ❒ Cough With Blood Or Phlegm ❒ Emphysema ❒ Pneumonia ❒ Shortness Of Breath ❒ Tuberculosis ❒ Wheezing Comments:

CIRCULATION	❒ Blood Clots ❒ Calf pain ❒ Swollen ankles ❒ Varicose veins ❒ Cold hands/feet ❒ Puffy eyes Comments:
CARDIOVASCULAR	❒ Arteriosclerosis ❒ Chest Pain ❒ Coronary Disease ❒ Heart Murmur ❒ Hypertension ❒ Heaviness Or Tightness In Chest ❒ High Blood Pressure ❒ High Cholesterol ❒ Low Blood Pressure ❒ Hypotension ❒ Palpitations ❒ Irregular Heart Beat ❒ Bradycardia ❒ Tachycardia ❒ Pacemaker ❒ Congenital Heart Defect(s): ___________________________ Comments:
DIGESTION	❒ Pain ❒ Burning indigestion ❒ Belching ❒ Regurgitation ❒ Vomiting ❒ Excessive gas ❒ Heavy bloating after meals ❒ Hemorrhoids ❒ Constipation (<1 BM/day) ❒ Diarrhea ❒ Both constipation & diarrhea ❒ Bloody stool Comments:
GENITO/ URINATION	Frequency: ______/ Day Color: __________ ❒ # Of Times At Night ________ ❒ Burning/ Painful ❒ Loss of urinary control ❒ Dribbling ❒ Blood in urine ❒ Foamy ❒ Frequent ❒ Profuse ❒ Retention ❒ Scanty ❒ Urgent ❒ Bedwetting ❒ Kidney/Bladder Infections ❒ Kidney/Bladder Stones ❒ Congenital Kidney Problems ❒ Frequent Urinary Tract Infections (UTI) ❒ Pain in kidney/groin area Comment:
MUSCLES & JOINTS	❒ Swelling in joints ❒ Pain/ache in joints ❒ Stiff joints ❒ Persistant muscle/bone pains ❒ Tremors/tics in muscles ❒ Muscle weakness/atrophy ❒ Numbness Comments:
NERVES	❒ Loss of taste, smell or touch ❒ Tingling sensations ❒ Tremors in limbs ❒ Uncoordinated muscle/limbs ❒ Neuropathic pain Comments:
MALE SYSTEM	❒ Prostate gland swollen/painful ❒ low sperm count ❒ Low motility ❒ Genital sores or lesions ❒ Genital discharge ❒ Erectile function difficulty ❒ Change in libido Comments:
FEMALE SYSTEM	❒ Irregular cycle ❒ Heavy/prolonged bleeding ❒ Vaginal discharge ❒ Painful menses ❒ Fibroids ❒ Missed menses or spotting ❒ discharge ❒ PMS or menopausal symptoms ❒ Ovarian cyst ❒ Pregnancies #: ______ ❒ Miscarriages/abortions #: _____ ❒ Unsatisfactory sex/change in libido ❒ Genital sores ❒ Last menstrual period date _________ ❒ Last menstrual period date: __________ Comments:
BREASTS	❒ Swelling ❒ Redness ❒ Lumps ❒ Nipple discharge ❒ Tenderness/pain Comments:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with medical and other healthcare, in accordance with this state's statutes.

Signature ____ Date ______________________

If the patient is a minor (under I8 yrs. of age), please supply parent/guardian information below:

Name of Parent or Guardian ____

Home Phone__________________________________ Cellular Phone__________________________________

Address (if different than patient) ____________________ City_______________ State_______ Zip Code__________

Parent/Guardian Signature ____ Date __________________