ELPIS HEALTHCARE

Health History/Review of Systems

Please circle as each applies to you:

EARS/NOSE/THROAT

Vision/hearing problems: YES / NO
Chronic ear infections: YES / NO
Chronic sinus infections: YES / NO
Deviated septum: YES / NO

ENDOCRINE

Thyroid disease hypo/hyper? YES / NO
Diabetes Type I/II? YES / NO

PULMONARY

Emphysema: YES / NO
Asthma/wheezing: YES / NO
Shortness o f breath: YES /
NO Chronic bronchitis: YES /
NO COPD: YES / NO

CARDIOVASCULAR

Heart disease: YES / NO
Palpitations/irregular heartbeat: YES / NO
Hypertension/high blood pressure: YES / NO
Hypotension/low blood pressure: YES / NO
Anaphylactic Reaction: YES / NO
High cholesterol: YES / NO
History of MI: YES / NO
Congestive Heart Failure: YES / NO
Coronary Artery Disease: YES / NO
Blood clots YES / NO
Blood thinners YES / NO

GENITO-URINARY

Urinate frequently: YES / NO
Erectile dysfunction: YES / NO
Blood in urine: YES / NO

NEUROLOGICAL

Dizziness/vertigo: YES / NO
History of Stroke/CVA/TIA: YES / NO
Seizures: YES / NO
Headache/migraines YES / NO

DERMATOLOGIC

Skin rash: YES / NO
Itching: YES / NO
Sores tha t won't heal: YES / NO

MUSCULOSKELETAL

Joint swelling/pain: YES / NO
Spine or neck pain: YES / NO
Multiple sclerosis: YES / NO
Arthritis: YES / NO
Osteoporosis: YES / NO
Numbness/tingling: YES / NO
Gout: YES / NO

OTHER

Chronic fatigue: YES / NO
Sleep disturbances: YES / NO
Surgical History: YES / NO
Chemotherapy Treatments: YES / NO
Have you had a Mastectomy: YES / NO

GASTROINTESTINAL YES / NO (not listed)_____

GERD/heartburn:

Gluten intolerance/celiac: YES / NO (not listed)_____

Have you tried to lose weight without medications? YES / NO

If so, lost how many lbs.?_____**How long were you on program?** _____

Have you tried to los e weight with appetite suppressants? YES / NO

Are you pregnant or nursing? YES / NO

Do you have any leg pain when walking? YES / NO

What Brings you to the office today?

_____
_____
_____
_____

Please list any and all prior surgeries or hospitalizations:

Surgery Performed **Year**

_____
_____
_____
_____
_____

Hospitalizations: **Year:**

_____
_____
_____
_____
_____

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FAMILY HISTORY

	Father	Mother	Brother / Sister	Child 1	Child 2	Child 3	Child 4
Good Health							
Poor Health							
Allergies / Asthma							
Diabetes							
Heart Trouble							
High Blood Pressure							
Cancer							

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Social / Personal History (if yes please indicate quantity)

Do you smoke? YES / NO **If so, how many packs /day?** _____

Do you drink tea? YES / NO **If so, how many cups /day?** _____

Do you drink soda? YES / NO **If so, how many cans /day?** _____

Do you drink alcohol? YES / NO **If so, how many drinks /week?** _____

Do you drink coffee? YES / NO **If so, how many cups /day?** _____

Do you drink milk? YES / NO **If so, how many cups /day?** _____

Do you have any drug / medication allergies? YES / NO If yes, please list: _____

_____

_____

_____

_____

List All Current Medication(s):

_____

_____

_____

_____

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Allergy History

Do you suffer from seasonal allergy symptoms? YES / NO

Rate the severity of your allergy symptoms: Light / Moderate / Severe

Have you ever suffered from watery, itchy, red eyes or have any discharge? YES / NO Light / Moderate / Severe

Have you ever suffered from sneezing or similar airway obstructions? YES / NO Light / Moderate / Severe

Have you ever suffered from stuffy or runny nose, Itchy throat? YES / NO Light / Moderate / Severe

When do you flair up due to allergies?

Winter [ ] Spring [ ] Summer [ ] Fall [ ]

Do you currently take prescription or OTC Allergy medication? YES / NO

If yes, list medications? _____

How effective are the medications in controlling your allergy symptoms?

Effective [ ] Not effective [ ] Some-what effective [ ]

Please check each condition that your allergies have affected:

Missed Work [ ] Home life interrupted [ ] Missed family time [ ]

Other pertinent Allergy information:

_____

_____

_____

_____

Have you ever had a severe anaphylactic reaction (swelling of the throat) that required emergency medical attention or use of an Epi-pen? YES / NO

Are you allergic to aspirin? YES / NO

Are you moderate / severe asthmatic; who carries a rescue inhaler? YES / NO

Within the past year have you had an allergy scratch test? YES / NO

Within the past year have you had Immunotherapy medications made for you? YES / NO

Do you have a history of taking OTC allergy medications or allergy shots? YES / NO

If yes, what kind: _____

Are you pregnant or think you might be? YES / NO / Not Applicable

Are you taking any Beta Blockers? YES / NO

Are you taking any Anti-Depressants? YES / NO

Have you ever been told you were allergic to Penicillin? YES / NO

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Food Sensitivity Survey

Patient Name: (Last), (First), (M)_____ **Date:**_____

Date of Birth:_____ **Gender: Male [ ] Female [ ] Height:**_____ **Weight:**_____

Please list all medications you are currently taking: _____

_____

Please complete the following food and chemical sensitivity questionnaire. **Circle each symptom based upon your experiences over the last 60 days**. This survey should be taken again after the completion of the Test, prior to reintroduction of "reactive" foods. Typically, 3-6 months after initial testing. This comparison will help to assess the success of the eating modification program.

Please circle the symptom s and rate the severity of the following:

Digestive Symptoms	Mild	Mod	Severe
Stomach Pains/Cramping	1	2	3
Constipation	1	2	3
Diarrhea	1	2	3
Reflux/Heartburn	1	2	3
Bloating	1	2	3
Gas	1	2	3
Nausea/Vomiting	1	2	3
Weight			
Inability to Lose Weight	1	2	3
Food Cravings	1	2	3
Water Retention	1	2	3
Sinus/Respiratory			
Stuffy/Runny Nose	1	2	3
Asthma	1	2	3
Chest Congestion	1	2	3
Chronic Cough	1	2	3
Wheezing	1	2	3
Frequent Sneezing	1	2	3
Head/Ears			
Migraines	1	2	3
Headaches	1	2	3

Emotional/Mental	Mild	Mod	Severe
Depression	1	2	3
Anxiety	1	2	3
Mood Swings	1	2	3
Irritability	1	2	3
Poor Concentration	1	2	3
Energy			
Fatigue	1	2	3
Hyperactivity	1	2	3
Lethargy	1	2	3
Restlessness	1	2	3
Skin Disorders			
Eczema	1	2	3
Dermatitis	1	2	3
Excessive Sweating	1	2	3
Rashes	1	2	3
Hives	1	2	3
Other Symptoms			
Joint Pain	1	2	3
Arthritis	1	2	3
Irregular Heartbeat	1	2	3
Chest Pains	1	2	3

Earaches	1	2	3	Muscle Aches	1	2	3
Ear Infection	1	2	3				
Ringing in Ears	1	2	3				
Eyes/Throat							
Itchy Eyes	1	2	3				
Watery Eyes	1	2	3				
Sore Throat	1	2	3				
Persistent Canker Sores	1	2	3				

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform us of any changes in my health history.

Signature:_____ **Printed Name:**_____ **Date:**_____