Patient Medical Questionnaire

This health questionnaire must be filled out in its entirety, including your physician's address or fax number. A letter will be sent to your physician to apprise him/her of your concerns as well as educational information/recommendations provided by Kelly Karpa.

Name _____ Telephone ( )_____ Date of Birth _____

Address _____

_____

Referred by: _____

In case of emergency: _____Telephone ( )_____

Occupation:_____Employer_____

Physician:_____

Physician's Address_____

_____

Physician's Telephone ( )_____Fax ( )_____

Please answer the following questions. If you answer "yes" to any of the following questions, please explain in the space provided below.

Do you have diabetes?	Yes	No
If yes, type 1 or type 2?	1	2
Do you have itching, tingling or burning skin?	Yes	No
Do you suffer from headaches?	Yes	No
If so, how long have you suffered, how many days per month, do you think that they may be hormonally-driven?	Yes	No
Are you pregnant?	Yes	No
Do you suffer from arthritis?	Yes	No
Do your muscles, bones, or joints bother you?	Yes	No
Have you been diagnosed with fibromyalgia?	Yes	No
Do you have high blood pressure?	Yes	No
Do you have heart problems, including mitral valve prolapse, racing pulse, uncontrolled heart beat?	Yes	No
Do you take medications that "thin the blood"?	Yes	No
Do you have high cholesterol or triglycerides	Yes	No
Do you have epilepsy or seizures?	Yes	No
Do you have any infectious diseases?	Yes	No
Have you ever been diagnosed with an autoimmune disease?	Yes	No
Are you immunocompromised for any reason?	Yes	No
Do you take any medications that suppress your immune system?	Yes	No
Have you ever been diagnosed with cancer? If so, were you treated with radiation or chemotherapy?	Yes	No
Do you suffer from shortness of breath?	Yes	No
Do you have difficulty breathing /wheezing?	Yes	No

Are you allergic to pollens, molds, animal dander, dust, mites, perfumes, chemicals, smoke, fabric store odors?	Yes	No
Do you currently take allergy shots?	Yes	No
Are you allergic to any foods/drugs? If so, which ones?	Yes	No
Do you have or have you ever had asthma?	Yes	No
Do you suffer from recurrent sinus problems?	Yes	No
Do sinus symptoms worsen on damp days or in musty, moldy environments?	Yes	No
Do symptoms worsen on days when the mold/pollen count is elevated?	Yes	No
Have you ever experienced mold-related problems in your home or office? Has your home or office ever flooded?	Yes	No
Do you have any allergies?	Yes	No
Do you have hives, psoriasis, dandruff, or chronic skin rashes?	Yes	No
Do you have acne?	Yes	No
Do you have recurrent ringworm, fingernail, toenail fungus, or jock itch?	Yes	No
Do you suffer from recurrent vaginal infections/discomfort?	Yes	No
Are your ovaries / testicles, thyroid gland, adrenals, and pancreas functioning as they should? Have you experienced menstrual irregularities, loss of libido, weight problems, or feeling inappropriately hot or cold?	Yes	No
Are you bothered by recurrent digestive problems, including bloating, belching, gas, constipation, abdominal pain, indigestion, or reflux?	Yes	No
Do you suffer from diarrhea?	Yes	No
Have you traveled to less developed countries? When? Where?	Yes	No
Have you ever been treated for worms or parasites?	Yes	No
Have you taken repeated or prolonged courses of antibiotics?	Yes	No
Do you suffer from chronic constipation?	Yes	No
Do you suffer from dry eyes, dry mouth?	Yes	No
Have you ever been diagnosed with attention-deficit hyper-activity disorder?	Yes	No
Do you suffer from fatigue?	Yes	No
Do you often feel “blue” or depressed?	Yes	No
Do you drink alcohol? If so, how much, how often and for how long have you been doing so?	Yes	No

Comments/Explanations for above questions:

_____

_____

_____

_____

_____

_____

Specific Concerns that you would like to discuss today:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medications that I currently use	Reason for Medication Use
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please continue on back, if necessary.