1601 Park Center Drive Suite 13
Orlando, FL 32835
Phone: 407-431-6649

ACC_____ ZYTO_____ DT_____

GENERAL INFORMATION

FEMALE VERSION

Name _____ Preferred Name _____

Age _____ DOB _____ Place of birth_____

Gender: Female ___ Email: _____

Married ____ Separated_____ Divorced____ Widowed____ Single____ Partnership____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____ Work Phone_____

Occupation _____ Nature of Business_____

Primary Care Physician_____

Referring Physician, if any_____

How did you hear about our clinic? Book _____ Website _____ Media_____ Friend/ family member_____

Other _____

Genetic Background. Please check appropriate option(s):

African American_____	Hispanic_____	Mediterranean_____	Asian_____
Native American_____	Caucasian_____	Northern European_____	Other_____

Emergency Contact_____ Phone Number_____

B.P _____ R.R_____

TEMP_____ PULSE_____

WEIGHT_____

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MEDICAL HISTORY

1- What is your reason for visiting the doctor today?

_____

_____

2- When do your reason first notice this problem?

3- Do you have any of the following? (Please circle "Yes" or "No". If yes, please explain.)

_____

_____

4- Do you smoke? Yes___ No___ How long? _____

5- Please indicate if you have been vaccinated against any of the following diseases:

- ❑ Smallpox
- ❑ Tetanus
- ❑ Diphtheria
- ❑ Pertussis
- ❑ Polio (oral)
- ❑ Polio (Injection)
- ❑ Mumps
- ❑ Measles
- ❑ Rubella (German measles)
- ❑ Typhoid
- ❑ Cholera

6- Have you ever been diagnosed with any of the following?

- ❑ Arthritis
- ❑ Asthma
- ❑ Bronchitis
- ❑ Cancer**
- ❑ Colitis
- ❑ Diabetes
- ❑ Diverticulosis
- ❑ Emphysema
- ❑ Heart Diseases
- ❑ High Blood pressure
- ❑ Kidney Diseases
- ❑ Pneumonia
- ❑ Seizures
- ❑ Sinusitis
- ❑ Stomach Ulcers
- ❑ Thyroid Disease

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Others_____ ** Specify_____

_____ _____

_____ _____

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MEDICAL HISTORY – WOMEN ONLY

Pregnancies _____ Caesarean _____

Vaginal Deliveries _____ Abortion _____

Living Children _____ Miscarriage _____

Age 1st period _____ Menses Frequency_____ For how long? _____

Last menstrual Period _____

Contraception Method _____

Hormone Replacement _____

Last Mammogram _____

Last PAP Smear _____

Last Bone Density Scan _____

Menopause _____

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REVIEW OF SYSTEMS

General

- ❑ Fever
- ❑ Chills/Cold all over
- ❑ Aches/Pains
- ❑ General Weakness
- ❑ Difficulty sweating
- ❑ Excessive Sweating
- ❑ Swollen Glands
- ❑ Cold hands & Feet
- ❑ Fatigue
- ❑ Difficulty falling asleep
- ❑ Night Walker
- ❑ Nightmares
- ❑ No dream recalls
- ❑ Early waking
- ❑ Daytime sleepiness
- ❑ Distorted Vision

SKIN:

- ❑ Cuts Heal slowly
- ❑ Bruise Easily
- ❑ Rash
- ❑ Pigmentation
- ❑ Changing Moles
- ❑ Calluses
- ❑ Eczema
- ❑ Psoriasis
- ❑ Dryness
- ❑ Oiliness
- ❑ Itching
- ❑ Acne
- ❑ Boils
- ❑ Hives
- ❑ Fungus on Nails
- ❑ Peeling Skin
- ❑ Cracking skin
- ❑ Shingles
- ❑ Nails Split
- ❑ White Spots/Lines on Nails
- ❑ Crawling Sensation
- ❑ Burning on Bottom of Feet
- ❑ Athletes Foot

HEAD:

- ❑ Poor Concentration
- ❑ Confusion
- ❑ Headaches:
- ❑ After Meals
- ❑ Severe
- ❑ Migraine
- ❑ Frontal
- ❑ Afternoon
- ❑ Occipital
- ❑ Afternoon
- ❑ Daytime
- ❑ Relieved by:
- ❑ Eating Sweets
- ❑ Concussion/Whiplash
- ❑ Mental Sluggishness
- ❑ Forgetfulness
- ❑ Indecisive
- ❑ Face Twitch
- ❑ Poor Memory
- ❑ Hair Loss

EYES:

- ❑ Sand in Eyes
- ❑ Double Vision
- ❑ Blurred Vision
- ❑ Poor Night Vision
- ❑ Bright Flashes
- ❑ Halo around Lights
- ❑ Eye Pains
- ❑ Dark Circles under Eyes
- ❑ Strong Light Irritates
- ❑ Cataracts
- ❑ Floaters in Eyes
- ❑ Visual hallucinations

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NOSE/SINUSES

- ❑ Stuffy
- ❑ Bleeding
- ❑ Running
- ❑ Discharge
- ❑ Watery Nose
- ❑ Congested
- ❑ Infection
- ❑ Polyps
- ❑ Acute smell
- ❑ Drainage
- ❑ Sneezing spells
- ❑ Post nasal drip
- ❑ No sense of smell
- ❑ Do the change of seasons tend to make your symptoms worse? Yes/No

If yes, is it worse in the:

- ❑ Spring
- ❑ Summer
- ❑ Fall
- ❑ Winter

MOUTH:

- ❑ Coated Tongue
- ❑ Sore Tongue
- ❑ Teeth Problems
- ❑ Bleeding Gums
- ❑ Canker Sores
- ❑ TMJ
- ❑ Cracked lips/ corners
- ❑ Chapped lips
- ❑ Fever blisters
- ❑ Wear dentures
- ❑ Grind teeth when sleeping
- ❑ Bad breath
- ❑ Dry mouth

THROAT:

- ❑ Mucus
- ❑ Difficulty Swallowing
- ❑ Frequent Hoarseness
- ❑ Tonsillitis
- ❑ Enlarged Glands
- ❑ Constant clearing of throat
- ❑ Throat closes up

EARS:

- ❑ Aches
- ❑ Discharge/Conjunctivitis
- ❑ Pains
- ❑ Ringing
- ❑ Deafness/Hearing loss
- ❑ Itching
- ❑ Pressure
- ❑ Wear a hearing aid
- ❑ Frequent infections
- ❑ Tubes in ears
- ❑ Sensitive to loud noises
- ❑ Hearing Hallucinations

NECK:

- ❑ Stiffness
- ❑ Swelling
- ❑ Lumps
- ❑ Neck glands swell

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GASTROINTESTINAL/DIGESTION

- ❑ Peptic/Duodenal Ulcer
- ❑ Poor Appetite
- ❑ Excessive Appetite
- ❑ Gallstones
- ❑ Gallbladder pain
- ❑ Nervous Stomach
- ❑ Full Feeling after meal
- ❑ Indigestion
- ❑ Heartburn
- ❑ Acid Reflux
- ❑ Hiatal Hernia
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Abdominal Pains/Cramps
- ❑ Gas
- ❑ Diarrhea
- ❑ Constipation
- ❑ Changes in Bowels
- ❑ Rectal Bleeding
- ❑ Tarry Stools
- ❑ Rectal Itching
- ❑ Use laxatives
- ❑ Bloating
- ❑ Belch frequently
- ❑ Anal itching
- ❑ Anal fissures
- ❑ Bloody stools
- ❑ Undigested food in stools

KIDNEY/URINARY TRACT:

- ❑ Burning
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Night time Urination
- ❑ Problem Passing Urine
- ❑ Kidney Pain
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Bladder infections
- ❑ Kidney infections
- ❑ Syphilis
- ❑ Bedwetting
- ❑ Have trichomonas

CIRCULATION/RESPIRATION:

- ❑ Swollen Ankles
- ❑ Sensitive to Hot
- ❑ Sensitive to Cold
- ❑ Extremities Cold or Clammy
- ❑ Hands/Feet go to sleep/numb
- ❑ High Blood Pressure
- ❑ Chest Pain
- ❑ Pain between shoulders
- ❑ Dizziness upon standing
- ❑ Fainting Spells
- ❑ High Cholesterol
- ❑ High Triglycerides
- ❑ Wheezing
- ❑ Irregular Heartbeat
- ❑ Palpitations
- ❑ Low exercise tolerance
- ❑ Frequent coughs
- ❑ Breathing heavily
- ❑ Frequently Sighing
- ❑ Shortness of breath
- ❑ Night Sweats
- ❑ Varicose Veins
- ❑ Mitral valve prolapses
- ❑ Murmurs
- ❑ Skipped heartbeat
- ❑ Heart enlargement
- ❑ Angina pain
- ❑ Bronchitis/Pneumonia
- ❑ Emphysema
- ❑ Croup
- ❑ Frequent colds
- ❑ Heavy/tight chest
- ❑ Past Heart Attack ? When _____
- ❑ Phlebitis
- ❑ Spider Veins

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JOINT/MUSCLES/TENDONS

- ❑ Pain wakes me up
- ❑ Weakness in Legs and arms
- ❑ Balance problems
- ❑ Muscle cramping
- ❑ Head injury
- ❑ Muscle Stiffness in Morning
- ❑ Damp weather bothers you

WOMEN'S HISTORY (for women only)

- ❑ Fibrocystic Breasts
- ❑ Lumps in breast
- ❑ Fibroid Tumors/Breast
- ❑ Spotting
- ❑ Heavy Periods
- ❑ Fibroid Tumors/Uterus
- ❑ Painful periods
- ❑ Change in period
- ❑ Breast soreness before period
- ❑ Endometriosis
- ❑ Non-period bleeding
- ❑ Breast soreness during period
- ❑ Vaginal Dryness
- ❑ Vaginal discharge
- ❑ Had partial/total hysterectomy
- ❑ Hot Flashes
- ❑ Mood Swings
- ❑ Concentration/Memory Problems
- ❑ Breast cancer
- ❑ Ovarian cysts
- ❑ Pregnant
- ❑ Infertility
- ❑ Decreased Libido
- ❑ Heavy Bleeding
- ❑ Joint Pains
- ❑ Headaches
- ❑ Weight Gain
- ❑ Loss of Control of Urine
- ❑ Palpitations

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EMOTIONAL:

- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Blackouts
- ❑ Amnesia
- ❑ Had shock therapy
- ❑ Frequently keyed up and jittery
- ❑ Shaky
- ❑ Startled by sudden noises
- ❑ Often feel suddenly scared
- ❑ Go to pieces easily
- ❑ Forgetful
- ❑ Listless
- ❑ Withdrawn feeling
- ❑ Feel "lost" in time
- ❑ Had nervous breakdown
- ❑ Cry often
- ❑ Feel groggy
- ❑ Unable to concentrate
- ❑ Short attention span
- ❑ Vision changes
- ❑ Have overused drugs
- ❑ Considered a nervous person
- ❑ Worried over little things
- ❑ Anxiety
- ❑ Been addicted to drugs
- ❑ Frustration
- ❑ Numbness
- ❑ Often break out in cold sweats
- ❑ Profuse sweating
- ❑ Depressed
- ❑ Been admitted for psychiatric care
- ❑ Often awakened by frightening dreams
- ❑ Family member had nervous breakdown
- ❑ Use tranquilizers
- ❑ Aggressive
- ❑ Misunderstood by others
- ❑ Irritable
- ❑ Easily flare in anger
- ❑ Feeling of hostility
- ❑ Fatigue
- ❑ Hyperactive
- ❑ Restless leg syndrome
- ❑ Considered clumsy
- ❑ Unable to coordinate muscles
- ❑ Have difficulty falling asleep
- ❑ Have difficulty staying asleep
- ❑ Daytime sleepiness

Physicians Notes:

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DENTAL HISTORY

Have you had sore gums (gingivitis) often over the years?	Yes ____	No _____
Has ringing in the ears (tinnitus) been present?	Yes ____	No _____
Have TMJ (temporal mandibular joint) problems been a concern?	Yes ____	No _____
Do you often have a 'metallic' taste in your mouth?	Yes ____	No _____
Do you have a lot of bad breath (halitosis) or white tongue (thrush)?	Yes ____	No _____
Have you worn or do you presently wear braces?	Yes ____	No _____
Do you have problems chewing?	Yes ____	No _____
Do you floss regularly?	Yes ____	No _____
Did your mother have dental fillings prior to giving birth to you?	Yes ____	No _____
Did you have fillings as a child?	Yes ____	No _____
If yes, about how many fillings did you have up to 18 yrs.?	# _____	
Did you have dental fillings as an adult?	Yes ____	No _____
If yes, about how many fillings did you have after to 18 yrs.?	# _____	
How many metal amalgam fillings do you have now?	# _____	
Did you play with mercury as a child or adult?	Yes ____	No _____
Have you eaten a lot of fish in your life?	Yes ____	No _____

List the approximate age and the type of dental work done from childhood until present:

Age	Describe Dental Work	Health Problems following dental work? (describe)

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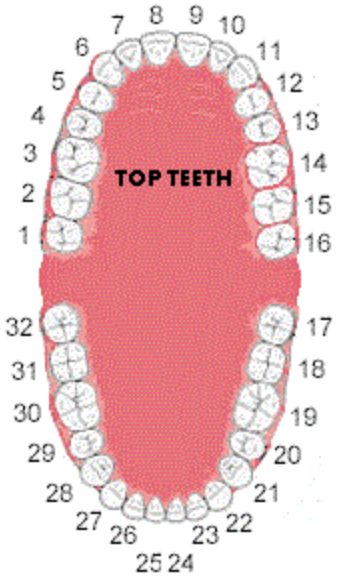
Please circle the tooth or teeth you have had or still have problems with. Please state what type of problem you have had, for example: root canal, crown, abscessed tooth, partials, etc. and indicate which teeth have fillings.



RIGHT SIDE

RECORD ANSWERS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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MEDICATIONS & SUPPLEMENTS

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

	< 5 times	**> 5 times**
Infancy/Childhood		
Teen		
Adulthood		

STEROID USE

Oral Steroids: How often have you taken oral steroids (e.g. Prednisone, Cortisone, etc.)?

	< 5 times	**> 5 times**
Infancy/Childhood		
Teen		
Adulthood		

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Indicate any medications you're currently taking or have taken in the last month:

- ❑ Acid Blocking Drugs
- ❑ Anti-anxiety medications
- ❑ Antibiotics
- ❑ Anticonvulsants
- ❑ Antidepressants
- ❑ Anti-fungal
- ❑ Aspirin/Ibuprofen
- ❑ Asthma inhalers
- ❑ Beta blockers
- ❑ Birth control pills/implant contraceptives
- ❑ Chemotherapy
- ❑ Cholesterol lowering medications
- ❑ Cortisone/steroids
- ❑ Diabetic medications/insulin
- ❑ Diuretics
- ❑ Estrogen or progesterone (pharmaceutical, prescription)
- ❑ Estrogen or progesterone (natural)
- ❑ Heart medications
- ❑ High blood pressure medications
- ❑ Laxatives
- ❑ Relaxants/Sleeping pills
- ❑ Testosterone (natural or prescription)
- ❑ Thyroid medication
- ❑ Acetaminophen (Tylenol)
- ❑ Ulcer medications
- ❑ Sildenafil citarte (Viagra or similar)

MEDICATION LOG

Please indicate the type of medications you are taking now. Please include non-prescription drugs.

Medication Name	Date started	Dated Stopped	Dosage	# per day

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SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name/Brand	Dose	Frequency	Dated Started	Reason for use

Have your medications or supplements ever caused you unusual side effects or problems?

Yes ____ No _____ If yes, please describe: _____
_____
_____

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ALLERGIES	
Medication/Supplement/Food	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

Primary Care Physician
Name, Address and Phone number:

_____

_____

_____

_____

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Initial Visit Notes

Name_____

Childhood

_____

_____

_____

_____

_____

_____

_____

_____

_____

Teenage _____

_____

_____

_____

_____

_____

Adult

_____

_____

_____

_____

_____

_____