

Lyme Resource Medical, PC
... **Patient Medical History & Symptom Information** ...

| *Name* | | *D.O.B.* | | *Age* | |

| *Address* | |

| | *SS#* | |

| *Home #* | | *Cell #* | |

| *Occupation* | | *Education [highest level]* | |

| *Employer* | | *Phone* | |

| *Address* | |

| |

| *Marital Status* | *Single* *Married* *Divorced* *Widowed*

| *Spouse's Name* | |

| *Occupation* | | *Phone* | |

| *Pharmacy* | | *Phone* | |

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

... Thank you for your cooperation ...

| *Referred by* | |

History of Present Illness

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

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Give a brief history of these problems. Approximately how long have they been present?

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

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.....

Have you ever been hospitalized for any illnesses?

.....	Date
.....	Date
.....	Date
.....	Date

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

.....
.....
.....

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

<i>Name of medication</i> -----	<i>Name of medication</i> -----
<input type="checkbox"/> <i>Antacid</i>	<input type="checkbox"/> <i>For heart disease</i>
<input type="checkbox"/> <i>Antibiotic</i>	<input type="checkbox"/> <i>For cholesterol</i>
<input type="checkbox"/> <i>Antispasmodic</i>	<input type="checkbox"/> <i>For cancer</i>
<input type="checkbox"/> <i>Laxative/cathartics</i>	<input type="checkbox"/> <i>For tuberculosis</i>
<input type="checkbox"/> <i>Antihistamine</i>	<input type="checkbox"/> <i>Cough/cold medication</i>
<input type="checkbox"/> <i>Muscle relaxant</i>	<input type="checkbox"/> <i>For ulcers</i>
<input type="checkbox"/> <i>Tranquilizer</i>	<input type="checkbox"/> <i>For liver</i>
<input type="checkbox"/> <i>Nasal decongestant</i>	<input type="checkbox"/> <i>For thyroid</i>
<input type="checkbox"/> <i>Pain pill/analgesic</i>	<input type="checkbox"/> <i>For blood pressure</i>
<input type="checkbox"/> <i>Aspirin</i>	<input type="checkbox"/> <i>Cortisone</i>
<input type="checkbox"/> <i>Anticonvulsant</i>	<input type="checkbox"/> <i>Contraceptive pill</i>
<input type="checkbox"/> <i>B-12 injection</i>	<input type="checkbox"/> <i>Anti-inflammatory</i>
<input type="checkbox"/> <i>Steroids</i>	<input type="checkbox"/> <i>Hormone pill</i>
<input type="checkbox"/> <i>Sedative</i>	<input type="checkbox"/> <i>Asthma medication</i>
<input type="checkbox"/> <i>Sleeping pill</i>	<input type="checkbox"/> <i>Potassium chloride</i>
<input type="checkbox"/> <i>Antidepressant</i>	<input type="checkbox"/> <i>For hypoglycemia</i>
<input type="checkbox"/> <i>Stimulant</i>	<input type="checkbox"/> <i>Chemotherapy</i>
<input type="checkbox"/> <i>Diet/weight pill</i>	<input type="checkbox"/> <i>Radiation</i>
<input type="checkbox"/> <i>Water pill/diuretics</i>	<input type="checkbox"/> <i>Other</i> -----

Vitamins and other supplements presently used:

|-----|

|-----|

|-----|

|-----|

Comments:

|-----|

|-----|

|-----|

Family History

Father:

| *If deceased, age at death* |.....|

| *Cause of death* |.....|

| *If alive, age* |.....|

Mother:

| *If deceased, age at death* |.....|

| *Cause of death* |.....|

| *If alive, age* |.....|

Brother(s):

| *Age(s)* |.....|

Sister(s):

| *Age(s)* |.....|

Family Illnesses (mark P for parents, GP for grandparents, and S for sibling):

| *Allergies* |.....|

| *Psoriasis* |.....|

| *Eczema* |.....|

| *Bronchitis* |.....|

| *Obesity* |.....|

| *Asthma* |.....|

| *Thyroid* |.....|

■ *High* ■ *Low*

| *Alcoholism* |.....|

| *Stroke* |.....|

| *Heart attack* |.....|

| *High blood pressure* |.....|

| *Ulcerative colitis* |.....|

| *Chron's disease* |.....|

| *Cancer* |.....|

| *Hypoglycemia* |.....|

| *Diabetes* |.....|

| *Chronic headaches* |.....|

| *Severe migraine* |.....|

| *Drug addiction* |.....|

| *Excessive medication* |.....|

| *Epilepsy* |.....|

| *Violent episodes* |.....|

| *Arthritis* |.....|

| *Gout* |.....|

| *Rheumatism* |.....|

| *Nervousness* |.....|

| *Depression* |.....|

| *Mental breakdown* |.....|

(with hospitalization)

| *Schizophrenia* |.....|

| *Other* |.....|

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 others
 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 six months Within Lifetime In Near Future
2. Death of child
 Last six months Within Lifetime In Near Future
3. Divorce
 Last six months Within Lifetime In Near Future
4. Jail
 Last six months Within Lifetime In Near Future
5. Death of family member or close friend
 Last six months Within Lifetime In Near Future
6. Personal injury
 Last six months Within Lifetime In Near Future
7. Marriage
 Last six months Within Lifetime In Near Future

8. ■ *Loss of employment*

- Last six months* *Within Lifetime* *In Near Future*

9. ■ *Pregnancy*

- Last six months* *Within Lifetime* *In Near Future*

10. ■ *Sexual difficulties*

- Last six months* *Within Lifetime* *In Near Future*

11. ■ *Financial reversal/gains*

- Last six months* *Within Lifetime* *In Near Future*

Sleep:

- | | | |
|---------------------------|---|----------------------------|
| ■ <i>Muscle twitching</i> | ■ <i>Very light</i> | ■ <i>Disturbing dreams</i> |
| ■ <i>Awake tired</i> | ■ <i>Heavy</i> | ■ <i>Dreamless</i> |
| ■ <i>Insomnia</i> | ■ <i>Difficult to fall off to sleep</i> | ■ <i>Frequent wakening</i> |
| ■ <i>Narcolepsy</i> | ■ <i>Difficult to stay asleep</i> | ■ <i>Medication</i> |
| ■ <i>Snoring</i> | ■ <i>Restless</i> | |

Energy:

- | | |
|--|---|
| ■ <i>Low</i> <input type="checkbox"/> <i>Constant</i> <input type="checkbox"/> <i>Intermittent</i> | ■ <i>Listless mental/physical</i> |
| ■ <i>High</i> | ■ <i>Lack of drive</i> <input type="checkbox"/> <i>Recent</i> <input type="checkbox"/> <i>Always</i> |
| ■ <i>Exhaustion, not refreshed by sleep</i> | ■ <i>Listless</i> <input type="checkbox"/> <i>During</i> <input type="checkbox"/> <i>After Exercise</i> |
| ■ <i>Fatigue</i> <input type="checkbox"/> <i>During</i> <input type="checkbox"/> <i>After exercise</i> | ■ <i>Other</i> |

Cravings:

- | | |
|-------------------------------|-----------------------|
| ■ <i>Water</i> | ■ <i>Tobacco</i> |
| ■ <i>Sweets and chocolate</i> | ■ <i>Salt</i> |
| ■ <i>Coffee or tea</i> | ■ <i>Sugar</i> |
| ■ <i>Bread</i> | ■ <i>Other</i> |
| ■ <i>Alcohol</i> | |

Favorite foods:

|.....|

|.....|

.....

.....

Comments:

.....

.....

.....

Smoking:

- Yes; how much?* |.....|
- No*

Alcohol:

- Yes; how frequent?* | *Daily, quantity* |.....| *Weekly*
 Social drinking (monthly or less) *Only with meals*
 Only on weekends
 Wine *Beer* *Spirits*
- No*
- Treatment for drinking problem* | *Past* *Present*

Comments:

.....

.....

.....

Activity and Exercise:

- Sedentary lifestyle*
Describe |.....|
- Walking*
Describe |.....|
- Gym*
Describe |.....|

Sports

| *Describe* |-----|

Comments:

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

Gain and/or lose at least 3-4lbs in one day

Weight control needed constantly

Difficult to control despite calorie counting

Compulsive eat (specially under emotionally stressful situations)

Underweight always

Overweight always (as child, adolescent, adult)

Cholesterol problems. On medication

Bulimia (secretive; have had treatment)

Anorexia (hospitalized)

Fluid relation

Frequent dieting

Frequent snacking

Other |-----|

Allergies:

Animals

Industrial Chemical

Aspirin

Pollens

Foods

Asthma

Molds

Sugar

Allergic Rhinitis

Aerosols

Wine and alcohol

Urticaria (hives)

Perfumes

Food additive

Conjunctivitis

Air conditioning

Milk products

Other |-----|

Auto exhaust

Antibiotics

Allergy Symptoms:

| *Have you been previous tested and treated?* |-----|

| *Shot* |-----| *How long?* |-----|

| *Physician* ||

| *Is your allergy condition* | *Constant* *Seasonal* *Only indoors* *Only outdoors*

Both indoors and outdoors *Food related* *Immediately after meals*

Delayed up to 24 hours

| *Is there one worse season?* ||

Travel:

Within USA and Canada

Outside country

Latin America/Mexico

Far East

Europe

Africa

| *Symptoms* | *Fevers* *Parasites* *Diarrhea* *Other* ||

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 molds, pollens, chemicals

Hypothyroid Syndrome:

Increase in weight

Decreased appetite

Fatigue easily

Mental sluggishness

Hair coarse, falls out

Headaches upon arising, wear off during day

- Ringing in ears
- Sleepy during day
- Sensitive to cold
- Dry or scaly skin
- Constipation

- Slow pulse, below 65
- Frequency of urination
- Impaired hearing
- Reduced initiative
- Failing memory

Hypoadrenal Syndrome:

- *Weakness, dizziness*
- *Chronic fatigue*
- *Low blood pressure*
- *Nails weak, ridges in nails*
- *Tendency to hives*
- *Arthritis tendencies*
- *Intestinal trouble*
- *Circulation poor*
- *Kidney trouble (edema)*
- *Crave salt*
- *Brown spots or bronzing of skin*
- *Allergies, tendency to asthma*
- *Weakness after colds, influenza*
- *Exhaustion, muscular and nervous*
- *Respiratory disorders*
- *Legs feel tired*

Hypoglycemia Syndrome:

- *Inward trembling*
- *Irritable before meals*
- *Sweating spells*
- *Craving for sweets*
- *Can not get started in the morning, need coffee*
- *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*
- *Prostatitis, impotence*
- *P.M.S*
- *Endometriosis*
- *Decrease sexual drive/desire*

- *Fatigue/lethargy*
- *Poor memory*
- *Spacey*
- *Abdominal pain, constipation*
- *Bloating*
- *Vaginal discharge*

- *Drowsiness*
- *Irritability, mood swings*
- *Headache*
- *Poor concentration*
- *Depression*

Basal Temperature Test

*Because the best time for the test is immediately upon awakening, shake down a thermometer and place it on the bedside table before going to bed. Immediately upon awoken place the thermometer snugly in the armpit for **10 minutes**, by the clock. Women should begin the test on the second day of menstrual flow. In young children, temperature should be recorded for seven days.*

	1	2	3	4	5	6	7
99.6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
99.4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
99.2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
99.0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
98.8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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