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New Patient Questionnaire Part I: ENT-Allergy Symptoms

*Please indicate the severity of your symptoms by **circling the number** that applies:*

0 = None ☺ 1 = Not so bad 2 = Moderate 😐 3 = Pretty bad 4 = Severe ☹

Nose symptoms

	☺	😐	☹
Sneezing spells	0 1	2 3	4
Itchy nose	0 1	2 3	4
Rub nose a lot	0 1	2 3	4
Stuffy nose	0 1	2 3	4
Runny, watery	0 1	2 3	4
Post-nasal drip	0 1	2 3	4
Nosebleeds	0 1	2 3	4
Can't smell	0 1	2 3	4
Nasal Polyps	0 1	2 3	4
Snoring	0 1	2 3	4
Sinus infections	0 1	2 3	4
"Sinus"	0 1	2 3	4

Throat symptoms

Clear often	0 1	2 3	4
Sore with fever	0 1	2 3	4
Sore, no fever	0 1	2 3	4
Thick mucus	0 1	2 3	4
Lump in throat	0 1	2 3	4
Hoarseness	0 1	2 3	4
Itching	0 1	2 3	4

Ear symptoms

Full, pressure	0 1	2 3	4
Pops, crackles	0 1	2 3	4
Itching in canal	0 1	2 3	4
Fluid in ears	0 1	2 3	4
Freq infections	0 1	2 3	4
Tubes inserted	0 1	2 3	4
Red ear lobes	0 1	2 3	4
Ringing	0 1	2 3	4
Dizziness	0 1	2 3	4
Hearing loss	0 1	2 3	4

Eye symptoms

Itching	0 1	2 3	4
Burning	0 1	2 3	4
Red	0 1	2 3	4
Watery	0 1	2 3	4
Puffy	0 1	2 3	4
Light sensitive	0 1	2 3	4
Dark circles	0 1	2 3	4

Chest symptoms

	☺	😐	☹
Cough	0 1	2 3	4
Wheezing	0 1	2 3	4
Asthma	0 1	2 3	4
Chest tightness	0 1	2 3	4
Freq bronchitis	0 1	2 3	4
Freq pneumonia	0 1	2 3	4
Congestion	0 1	2 3	4

Skin symptoms

Itchy rash	0 1	2 3	4
Itchy, no rash	0 1	2 3	4
Hives	0 1	2 3	4
Eczema	0 1	2 3	4
Cracked nails	0 1	2 3	4
Easy bruising	0 1	2 3	4
Puffy hands /feet	0 1	2 3	4
Seborrhea /dandruff	0 1	2 3	4
Diaper rash	0 1	2 3	4
Colorless rash (Esp. cheeks, arms)	0 1	2 3	4

Gastrointestinal

Swollen /sore lips	0 1	2 3	4
Drooling	0 1	2 3	4
Canker sores	0 1	2 3	4
Mottled tongue	0 1	2 3	4
Itchy roof of the mouth	0 1	2 3	4
Bad breath	0 1	2 3	4
Belching	0 1	2 3	4
Nausea	0 1	2 3	4
Belly aches /colic	0 1	2 3	4
Bloated, gas	0 1	2 3	4
Diarrhea	0 1	2 3	4
Constipation	0 1	2 3	4
Irritable bowel /Colitis	0 1	2 3	4

Nervous system

	☺	😐	☹
Irritable	0 1	2 3	4
Restless/Hyper	0 1	2 3	4
Attention deficit	0 1	2 3	4
Behavior probs	0 1	2 3	4
Learning disability	0 1	2 3	4
Listless, tired	0 1	2 3	4
Chronic fatigue	0 1	2 3	4
Cries often	0 1	2 3	4
Sad/depressed	0 1	2 3	4
Clumsy	0 1	2 3	4
Sleeps poorly	0 1	2 3	4
Nightmares	0 1	2 3	4
Spaced out	0 1	2 3	4
Seizures	0 1	2 3	4

Urinary system

Bed-wetting	0 1	2 3	4
Wet pants in the day	0 1	2 3	4
Up to urinate at night	0 1	2 3	4
Pain on urination	0 1	2 3	4
Burning	0 1	2 3	4
Urgency	0 1	2 3	4
Bloody urine	0 1	2 3	4
Symptoms change with seasons	0 1	2 3	4

Miscellaneous

Headaches	0 1	2 3	4
Migraines	0 1	2 3	4
Neck/backaches	0 1	2 3	4
Joint aches	0 1	2 3	4
Leg cramps	0 1	2 3	4
Xs perspiration	0 1	2 3	4
Freq. Infections	0 1	2 3	4
Vaginal Irritation	0 1	2 3	4
Irregular Heartbeat	0 1	2 3	4
Weakness	0 1	2 3	4

Timing of symptoms

Name: _____ Date: _____

Check all that apply.

( ) January – February
( ) March – April
( ) May – June
( ) August – September
( ) October – November
( ) All Year
( ) Worst on waking
( ) Worst at bedtime

Are symptoms worse:
Check all that apply.

( ) Inside your home
( ) At work (or school)
( ) In the city
( ) In the country
( ) Mowing grass
( ) Raking leaves
( ) Dig in garden
( ) Walk in woods
( ) Work in barn
( ) Work in basement

Do weather changes make you feel worse?

( ) Cold weather
( ) Dry – breezy weather
( ) Damp weather
( ) Hot – humid
( ) Temperature changes
( ) Before or just after rain

Pets in the home:

( ) Cat
( ) Dog
( ) Bird
( ) Hamster/Gerbil/rodent
( ) Rabbit

Other animal exposure

( ) Horse
( ) Cattle
( ) Other: _____

Known allergies (list):

Home Environment:

Heating:

( ) Electric
( ) Gas heat
( ) Oil heat
( ) Propane tank heat
( ) Wood heat
( ) Other:

Air conditioning:
( ) Central air
( ) Window units

Other factors:
( ) Air filters
( ) Dehumidifier
( ) Humidifier

Other exposures:
( ) Feather pillow
( ) Down comforter
( ) Allergen-proof cases
- cover mattress & pillow
( ) Cigarette smoke

General:

( ) Family history of allergies
( ) Have you been treated for allergies (shots/drops)?
( ) Exposed to cigarette smoke?
( ) Sensitive to chemicals?
(Please circle any that apply)
perfumes
detergents
oven cleaner
bug spray
gas fumes
fingernail polish
- Other (please list):

Do chemicals cause you:
( ) Severe trouble
( ) Moderate problems
( ) Mild symptoms

Part II: Food and Yeast Allergy Questions:

(Modified from Crook)

History:

Have you taken antibiotics for acne for 1 month or longer?
Includes:
tetracycline (Doxycycline, Minocin) and erythromycin.
( ) Yes

Have you taken "broad-spectrum" antibiotics for infections (respiratory, urinary, or other) for 2 months or 4 times in 1 year?
Includes Keflex, Ampicillin, Amoxicillin, Ceclor, Bactrim, Septra, Ceftin, Cefzil, Cipro, Levaquin, Avelox, Tequin, Zithromax, Ketek and more
( ) Yes

Have you ever taken a "broad-spectrum" antibiotic, even once?
Includes most intravenous (IV) antibiotics
( ) Yes

Have you used oral or injected steroid drugs (Cortisone, Prednisone, Medrol, Decadron) even one time?
( ) More than 2 weeks
( ) For 2 weeks or less

Have you taken birth control pills:
( ) More than 2 years
( ) For 6mos to 2 years

Have you been pregnant:
( ) 2 or more times
( ) One time

Have you had persistent problems with vaginitis, prostatitis or trouble with your reproductive organs?
( ) Severe or persistent
( ) Mild or moderate

Part II, *continued*

History:

Have you had athlete's foot, ringworm, "jock itch" or other fungus problems of skin, ears or nails?
( ) Yes, severe - persistent

( ) Yes, mild or moderate

Do you crave:
( ) Sugar
( ) Bread, chips or "starches"
( ) Alcoholic drinks

List other foods you crave:

List any foods you dislike or foods that disagree with you:

Symptoms ("major"):

	☺	😐	☹
Fatigue-lethargy	0	1 2	3 4
You feel drained	0	1 2	3 4
Poor memory	0	1 2	3 4
You feel spacey or unreal	0	1 2	3 4
Numbness, burning or tingling	0	1 2	3 4
Headaches	0	1 2	3 4
Muscle aches	0	1 2	3 4
Muscles weak	0	1 2	3 4
Joint pain, swelling	0	1 2	3 4
Abdominal pain	0	1 2	3 4
Hemorrhoids	0	1 2	3 4
Constipation	0	1 2	3 4
Diarrhea	0	1 2	3 4
Bloating, belching, intestinal gas	0	1 2	3 4
Vaginal burning, itching or discharge	0	1 2	3 4
Prostatitis	0	1 2	3 4
Impotence	0	1 2	3 4
Loss of sexual desire or feelings (libido)	0	1 2	3 4
Endometriosis	0	1 2	3 4
Infertility	0	1 2	3 4

	☺	😐	☹
Menstrual cramps	0	1 2	3 4
Irregular menses	0	1 2	3 4
PMS	0	1 2	3 4
Attacks of anxiety or crying	0	1 2	3 4
Cold hands, feet or chilliness	0	1 2	3 4
Shaky or irritable when hungry	0	1 2	3 4

Symptoms ("minor"):

	☺	😐	☹
Drowsiness	0	1 2	3 4
Irritability or jitteriness	0	1 2	3 4
Lack of coordination	0	1 2	3 4
Unable to concentrate	0	1 2	3 4
Frequent mood swings	0	1 2	3 4
Insomnia	0	1 2	3 4
Bruise easily	0	1 2	3 4
Skin rashes or chronic itching	0	1 2	3 4
Eczema, psoriasis or hives	0	1 2	3 4
Food allergy, sensitivity or intolerance	0	1 2	3 4
Allergic to 3 or more drugs	0	1 2	3 4
Indigestion or Heartburn	0	1 2	3 4
Mucus in stool	0	1 2	3 4
Rectal itching	0	1 2	3 4
Dry mouth or throat	0	1 2	3 4
Blisters in mouth	0	1 2	3 4
Blisters in throat	0	1 2	3 4
Bad breath	0	1 2	3 4
Odor: feet, body or hair even after washing	0	1 2	3 4
Nose congestion or postnasal drip	0	1 2	3 4
Nose itches	0	1 2	3 4

	☺	😐	☹
Sore throat, lump in throat	0	1 2	3 4
Laryngitis, loss of voice	0	1 2	3 4
Cough or recurrent bronchitis	0	1 2	3 4
Pain, tightness in throat	0	1 2	3 4
Wheezing, shortness of breath	0	1 2	3 4
Urinary frequency	0	1 2	3 4
Burning urination	0	1 2	3 4
Spots before eyes or vision trouble	0	1 2	3 4
Eyes burn, tearing	0	1 2	3 4
Ear infections, fluid in ears	0	1 2	3 4
Ear pain, hearing loss	0	1 2	3 4
Dizziness, loss of balance	0	1 2	3 4
Pressure above ears, feeling of head swelling	0	1 2	3 4

Part III: Thyroid

History: Family

Has anyone in your family had thyroid trouble of any kind?
(please circle)

- Mother/ Father
- Sister/ Brother
- Grandmother/ Grandfather
- Daughter/ Son
- Aunt/ Uncle
- Niece/ Nephew

What type of trouble?
(circle if you know)

- Low thyroid/ high thyroid
- Goiter
- Thyroiditis
- Cysts
- Benign tumor or mass
- Cancer

Part III, Thyroid *cont.*

Personal History:

Note your height and weight when you were 18 years old
(or when you graduated from High School):

_____Ft/in. _____lbs.

Has a doctor ever diagnosed you with thyroid trouble?
(Please circle)

- Yes/ No

If "yes," what kind?

- Low thyroid/ high thyroid
- Goiter
- Thyroiditis
- Cysts
- Benign tumor or mass
- Cancer

How was the diagnosis made?

- Physical exam
- Body temperatures
- Blood test
- Needle biopsy
- Scan
- Operation
- Other:

How were you treated?

- No treatment
- Pills
- Radioactive iodine
- Operation
- Other:

Do you now take thyroid pills?

- Yes / No

If so, please fill in the details:

Name(s) of pills:

Strength of pills:
_____(mg, mcg, grains)
Dose used:
How many pills at a time:
_____
How many times a day:
_____
What time(s) of day:
_____
How long have you used thyroid medication?
_____Years

Has your medication been changed recently?

- Yes/ No

The change made you feel:
(Please circle one)

- Better/ Same/ Worse

Symptoms ("major"):

	☺	😐	☹
Decreased energy, fatigue	0 1 2 3 4		
Weight gain or struggles	0 1 2 3 4		
Feel "too hot"	0 1 2 3 4		
Feel "too cold"	0 1 2 3 4		

Symptoms ("minor")

Hair thinning or excessive loss	0 1 2 3 4		
Headaches	0 1 2 3 4		
"Brain fog"- trouble with learning, memory, making decisions	0 1 2 3 4		
Depression	0 1 2 3 4		
Irritability	0 1 2 3 4		
Can't fall asleep	0 1 2 3 4		
Can't stay asleep	0 1 2 3 4		
Tired on waking	0 1 2 3 4		
Snoring	0 1 2 3 4		
Stop breathing while asleep	0 1 2 3 4		
"Lump in throat" when swallow	0 1 2 3 4		
Dislike tight collars	0 1 2 3 4		
Sore or tender in lower neck	0 1 2 3 4		

	☺	😐	☹
Chest tightness, sighing	0 1 2 3 4		
Heart palpitations	0 1 2 3 4		
Gastritis, use Tums, Nexium, etc.	0 1 2 3 4		
Abdominal gas and bloating	0 1 2 3 4		
Constipation	0 1 2 3 4		
Diarrhea, colitis	0 1 2 3 4		
Fertility problems, miscarriages	0 1 2 3 4		
Menstrual problems w/ flow or irregularity	0 1 2 3 4		
Loss of sex drive	0 1 2 3 4		
Muscle aches, esp. low back	0 1 2 3 4		
Stiff joints	0 1 2 3 4		
Cold feet & hands	0 1 2 3 4		
Dry skin	0 1 2 3 4		
Brittle nails	0 1 2 3 4		
Carpal tunnel problems	0 1 2 3 4		

Please remember there is no symptom that is unique to the thyroid. Every one of these symptoms could be caused by a number of different problems. The pattern gives us information.

Part IV: Adrenal

History:

Has anyone in your family ever had adrenal problems?

- Yes/ No

Have you ever been diagnosed with or treated for adrenal gland problems?
(Please circle):

- Yes/ No

If "yes," please give details:

Part IV: Adrenal *cont.*

History: (please circle)

Have you recently been treated with steroid drugs – pills or shot? (Including cortisone, Prednisone, Medrol, Celestone, Decadron, Kenalog and others)

- Yes/ No

Have you ever had a dramatic or bad reaction to using a steroid drug?

- Yes/ No

Ladies:
Have you polycystic ovaries (lots of cysts on ovaries)?

- Yes/ No

Gents:
Are you the only man in your family without hair loss?

- Yes/ No

Symptoms:
Do you have problems with:

	☺	😐	☹
Ladies:			
Irregular periods	0	1	2 3 4
Fertility problems	0	1	2 3 4
Peri-menopausal troubles	0	1	2 3 4
Hair where it shouldn't be	0	1	2 3 4
Gents:			
Prostate trouble	0	1	2 3 4
Erectile dysfunction	0	1	2 3 4
Everybody:			
Low energy	0	1	2 3 4
Lack endurance	0	1	2 3 4
Loss of strength	0	1	2 3 4
Reduced libido (sexual interest)	0	1	2 3 4

Everybody:	☺	😐	☹
Lightheaded when get up quickly	0	1	2 3 4
Low blood pressure	0	1	2 3 4
Blood pressure up and down	0	1	2 3 4
Crave salt	0	1	2 3 4
Up at night to urinate	0	1	2 3 4
Low potassium on no diuretic	0	1	2 3 4
High blood sugar	0	1	2 3 4
Low blood sugar	0	1	2 3 4
Shallow sleep	0	1	2 3 4
Wake up tired	0	1	2 3 4
Can't remember dreams	0	1	2 3 4
Trouble handling stress	0	1	2 3 4
Easily upset or angered	0	1	2 3 4
Panic attacks	0	1	2 3 4
Slow recovery from infections	0	1	2 3 4
Slow recovery from operations	0	1	2 3 4

Part V: Stress

Prenatal:

How old was your mother when you were born?

_____

Among the children in your family, you rank (circle one):

- Oldest
- Middle
- Youngest
- Only child

If you have siblings, how many?
Brothers:_____

Sisters: _____
What was your mother's state of mind during her pregnancy with you? (circle all that apply)

- Happy
- Angry
- Stressed
- Fearful
- Don't know

How was your mother's health when she was pregnant with you? (circle)

Well
Ill; having problems with:
- High blood pressure
- Diabetes
- Infection
- Accident or injury
- Operation
- Alcohol or drug use
- Bed-rest for premature labor

How was your mother's relationship with your father during your pregnancy?

- Good
- Strained
- Bad
- None at all

Perinatal:

Did your mother have any problems during your labor and delivery? (please circle):

- Premature rupture of membranes
- Premature labor
- Prolonged labor
- Emergency C-section
- Other: *Please give any known details.*

Part V: Stress *cont.*

History

Did you have any problems during your birth? (circle)

- Premature or late birth
- Fetal distress
- Cord around neck
- Blue baby
- Meconium aspiration
- Under-developed lungs
- Jaundice – longer in hospital than usual
- Time in a neonatal isolette
- Other (please list if known):

What did you weigh at birth?

_____

First year of life:

As a newborn, were you
( ) Breast-fed
( ) Bottle-fed

In your first year of life, did you have problems with (please circle all that apply):

- Formula intolerance, Change(s)
- Breast-feeding problems
- Reflux and vomiting
- Colic and crying
- Sleeplessness for more than 6mos
- Eczema
- Bad diaper rashes
- Frequent ear infections
- Constantly running nose
- Operations
- Chest infections, asthma
- Chronic diarrhea or constipation
- Other:

Were your developmental milestones (talking, walking):
- Early
- Average – on time
- Late

Pre-school age:

During your pre-school years, how did your parents relate to each other?

- Happy and peaceful
- Dealt well with differences
- "Strained"
- Fought in front of kids
- Really badly

As a small child, did you need medical treatment for:

- Ear infections
- Asthma
- Pneumonia
- Croup
- Tonsils/ Adenoids
- Other:

_____

Did you have any serious injuries or operations during your preschool years?

- No
- Yes - if so, please list:

_____

When you remember your pre-school years, do you feel:

- Happy
- Neutral
- Sad or angry
- No memories

School age: Elementary

When you started going to school, how did you like it?

Loved it
Liked it
No bad feelings
Hated it
No memories of it

What was the best thing about school?

_____

What was the worst thing about school?

_____

In elementary school, what was your personality like? (please circle)

- Outgoing
- Average
- Shy

Have you ever been:

- Teacher's Pet
- Class Clown
- Class Rebel
- Scapegoat
- Other:

What grades did you get in Elementary school?

_____

Back then your height was:

- Tall
- Average
- Small

And your build was:

- Thin
- Average
- Heavy-set

Did you then have any health problems requiring medical care?

- No
- Yes - if so, please list:

Did you have any injuries or operations while in elementary school?

- No
- Yes - if so, please list:

Part V: Stress *cont.*

Were you "hyperactive" or given drugs for your behavior when in school?

- No
- Yes - if so, list which:

School Age: Jr. High

Did you have a big problem with acne? (circle)

- No
- Yes

Did your body type change?

- No
- Yes, from thin to heavier
- Yes, from heavy to thinner

Did your grades change in Middle or Jr. High school?

- No
- Yes, they got worse
- Yes, they got better
- Yes, they had ups & downs

If yes, why?

_____

Did your behavior or relations with teachers and friends suffer in Middle school?

- No
- Yes

High school age:

Did your grades change in High school?

- No
- Yes, they got worse
- Yes, they got better
- Yes, they had ups & downs

If yes, why?

_____

While in High school, did you have problems with: (circle)

- Relations with classmates
- Run-ins with the Law
- Alcohol or drug use
- Health problems
- Operation or injury

Activity and exercise during school years:
(check a box with your estimate)

	Elem.	Middle	High
None			
Occasional			
Frequent			
Constant			

During your childhood and through High school, have you been bereaved by the loss of a loved one?

- No
- Yes (Please explain, if you wish)

During any time in your childhood or teen years, have you suffered from physical or emotional abuse?

- No
- Yes

(You need not answer, as you prefer.)

Have you suffered from other stressful events at any time in your life that have not been covered here? You may use this space to note them. Go to the back side of this paper if you need to write more.

Thank you.

Part VI: OB-GYN

Men: Your section is next!

Menarche:

How old were you when you had your first menstrual period?

_____

Did your figure "fill out" earlier than your friends' did?

- No
- Yes, at age_____years.

Compared to your friends, did you start having periods: (circle)

- At a younger age
- At the same age
- At an older age
- Don't really know

Compared to the women in your family, did you start having periods:

- At a younger age
- At the same age
- At an older age
- Do not know

Early menstrual history

During your first four years of having periods, how many days did the flow last?

_____days

During these years, were your menstrual cycles: (circle whatever applies)

- Regular, even and easy
- Irregular and unpredictable
- Painful, requiring pain pills (check): Over the counter / Prescription
- Accompanied by heavy flow
- Accompanied by clots for

_____days

Part VI: OB-GYN *cont.*

Did you have to miss school because of menstrual problems?

- No
- Occasionally
- Half of the time
- More than half the time
- Monthly

Did you ever need to take "the Pill" to control your menstrual problems?

- No
- Yes, at age:

_____years

Reason:

Reproductive history:

As each applies, please indicate the number you have had:

- Pregnancy _____
- Miscarriage _____
- Therapeutic abortion _
- Birth of living child ___

If you have been pregnant, did you have complications with: (circle all that apply)

- Severe nausea or fatigue
- Retain too much fluid
- High blood pressure
- Pre-eclampsia

- Excessive weight gain
- Gestational diabetes
- Put on bed-rest
- Labor had to be induced
- Other: _____

If you've had children, please indicate their birth weights and current ages
_____, _____yrs

_____, _____yrs

_____, _____yrs
How much weight did you gain with each pregnancy?

Did you have any problems with labor and delivery?

- No/ Yes

If "yes," please indicate:
- Premature rupture of the membranes
- Premature labor
- Emergency C-section
- Excessive bleeding
- Infection
- Other:

In the months after delivery, did you any problems with:

- Postpartum depression ("Baby Blues") for_____wks
- Thyroiditis
- Other:

Was your weight a problem after your pregnancy?

- No
- Yes.

If so, please explain:

Hormone contraception:

Have you ever taken the birth control pill?

- No
- Yes, for _____months/yrs.
(circle which)

Have you used any other hormone contraception? (Provera, patch, ring, Mirena)

- No
- Yes

If "yes," which?

Have you ever had difficulty in tolerating hormone birth control?

- No/ Yes

Have you needed to try several different kinds of hormone contraception before finding a good one?

- No/ Yes

Have you been <u>unable</u> to find a form of hormone birth control that you could tolerate?

- No/ Yes

If "yes," what symptoms?

_____

Later menstrual history:

Have you ever had problems with premenstrual syndrome (PMS)?

- No/ Yes

If "yes," please answer:

- symptoms last_____days
- which treatment has helped you the most?

_____

What symptoms has your PMS given you?

Mood swings:
Irritable/angry
Weepy/sad
Headaches
Fluid retention
Pain (please note where):
_____
Other:
_____

Whether or not you are still having menstrual cycles, please indicate the date (actual or approximate) on which your last normal menstrual period started:

_____

Part VI: OB-GYN *cont.*

For women now cycling:

If you have PMS, how long does it bother you?

- A day or two
- A week
- Two weeks
- Other:

_____

Do you have mid-cycle problems (usually thought due to ovulation)?

- No
- Yes

If "yes," please describe:

_____

How many days does your menstrual flow last?

_____days

Do you pass clots?

- No
- Yes, little ones
- Yes, big ones

If "yes," for how long?
_____days

Do you have painful menstrual flow?

- No
- Yes

If "yes," for how long?
_____days

From the day your menstrual flow starts to the day the flow starts again (usually 28 days), how long are your menstrual cycles?

_____days
(If irregular, please give a range)
Have your cycles or the pattern of your menstrual flow changed recently?

- No
- Yes
If "yes," in what way?

_____

Postmenopausal women:

Did you have problems as you moved into menopause?

- No
- Yes
If "yes," please describe:

Are you taking any form of hormone replacement therapy right now?

- No
- Yes
If "yes," list which:

_____

Have you ever taken hormone replacement treatment?

- No
- Yes
If "yes," which:

-and for how long:
_____months/yrs

Are you now bothered by any symptoms that could come from low hormones? (circle)

- Vaginal dryness, irritation
- Lose urine on cough, strain
- Hot flashes or insomnia
- Loss of libido (desire)
- Trouble thinking, planning
- Mood swings, depression
- Loss of bone calcium
- Loss of figure or "Other":

Family GYN history:

If anyone – mother, sister, mother's family or father's family – has experienced these important hormone-related problems, please circle the condition and then indicate who had it.

- Multiple cysts of ovaries

- Fibroid tumors of Uterus

- Fibrocystic breasts

- Endometriosis

- Cancer of cervix

- Cancer of uterus

- Cancer of ovary

- Cancer of breast

- Bone loss or fracture

- Cancer of the colon

- Heart attack or stroke

- Alzheimer's disease

Quick double-check: Have you personally had any of these problems? If so, circle here:

- Multiple ovarian cysts
- Fibroid tumors of uterus
- Fibrocystic breast disease
- Endometriosis
- Cancer of:
Cervix, Uterus, Ovary, Breast

Do you have ideas, concerns or questions about hormone replacement therapy? Please note them in the space below for our discussion:

Part VII: For Men

Andropause symptoms

	☺	😐	☹
Reduced libido (sex drive)	0	1 2	3 4
Erections are less strong	0	1 2	3 4
Low volume on ejaculation	0	1 2	3 4
Reduced strength and/or endurance	0	1 2	3 4
Deterioration of your athletic ability	0	1 2	3 4
Loss of muscle	0	1 2	3 4
Loss of height	0	1 2	3 4
Lack of energy	0	1 2	3 4
Less "enjoyment of life"	0	1 2	3 4
Feel sad and/or grumpy	0	1 2	3 4
Falling asleep after dinner	0	1 2	3 4
Deterioration in your work performance	0	1 2	3 4
Growing breasts	0	1 2	3 4
Slow or weak urine stream	0	1 2	3 4
Frequent urination	0	1 2	3 4
Waking to urinate	0	1 2	3 4
Voice weak/high	0	1 2	3 4

Part VIII: Blood sugar and insulin resistance

Have you ever been tested for hypoglycemia? (circle)

- No
- Yes

If "yes," what test was done?

_____

- What was found?

Name: _____ Date: _____

_____

Do you have diabetes mellitus?

- No/ Yes

If “yes,” which type?

- Type I “juvenile”
- Type II “adult-onset”

And for how long?
_____years

Are you following any particular diet plan, such as Weight Watchers,’ Atkins,’ South Beach or ADA?

- No/ Yes

If “yes,” which one?

_____

If you are following a diet plan, could you do it better?

- No/ Yes

- If yes, how?

What did you weigh:
- one year ago _____
- five years ago _____
- ten years ago _____

When you wake up in the morning, are you hungry?

- No/ Yes.

When you get up in the morning, what is the first thing you drink?

_____

How long have you been awake when you drink this?

_____

When get up in the morning, what is the first solid food you eat?

_____

How long have you been awake when you first eat?

_____hours

Do you snack before lunch?

- No/ Yes

Do you snack after lunch?

- No/ Yes

Do you crave bread, cereal, chips or starchy snacks?

- No/ Yes

Do you crave sugar?

- No/ Yes

Have you found that eating sugar makes you feel badly?

- No
- Yes

If “yes,” how does it make you feel?

_____

Do you use sweeteners?
(circle all that you use)

- Stevia (“natural” herb)
- Splenda (sucralose)
- Nutra-sweet (aspartame)
- Sweet&Low (saccharine)
- Fructose
- “Alcohol sugars”
- Other:

Do you drink soft drinks (soda pop)?
(circle all that you use)

- Regular
- Diet
- Decaf or “Caffeine-free”
- No caffeine

How many cans or bottles of soda pop do you drink daily?
_____=_____oz.

Do you regularly chew gum, use hard candy or breath mints?

- No
- Yes

If “yes,” what do you use?

_____

- and how many packs daily?

_____

Do you eat desserts?

- Never
- Rarely
- Less than half the time
- More than half the time
- Every day

Do you eat snacks around bed-time?

- Never
- Rarely
- Less than half the time
- More than half the time
- Every day

Do you wake up at night and need to snack or have a drink (besides water)?

- No
- Yes

If “yes,” how often:

_____

- and on what do you snack?

_____

Sugar & insulin symptoms
(circle all that apply, by severity)

	☺	😐	☹
Craving sweets	0	1 2	3 4
Need snacks often	0	1 2	3 4
Feel great after eating sugar	0	1 2	3 4
Feel badly after eating sugar	0	1 2	3 4
Digestive disturbances	0	1 2	3 4
	☺	😐	☹
Sighing and			

yawning 0 1 2 3 4
Drowsiness 0 1 2 3 4
Exhaustion 0 1 2 3 4
Faintness 0 1 2 3 4

Nervousness 0 1 2 3 4
Worrying, unprovoked anxiety 0 1 2 3 4
Act anti-social 0 1 2 3 4
Overly aggressive behavior 0 1 2 3 4
Crying spells 0 1 2 3 4
Loss of sex drive 0 1 2 3 4
Insomnia 0 1 2 3 4

Depression 0 1 2 3 4
Forgetfulness 0 1 2 3 4
Poor concentration 0 1 2 3 4
Confusion 0 1 2 3 4
Indecisiveness 0 1 2 3 4

Headaches 0 1 2 3 4
Blurred vision 0 1 2 3 4
Dizziness 0 1 2 3 4
Poor coordination 0 1 2 3 4
Numbness 0 1 2 3 4

Sense of internal trembling 0 1 2 3 4
Itching, crawling skin sensations 0 1 2 3 4
Heart palpitations, rapid pulse 0 1 2 3 4
Tremors, shakes 0 1 2 3 4
Cold sweats 0 1 2 3 4
Unconsciousness 0 1 2 3 4

Muscle pains 0 1 2 3 4
Leg cramps 0 1 2 3 4
Muscle twitches, jerks 0 1 2 3 4

Part IX: Energy & Sleep

Please pick a number from 1-10 to describe your average energy for the past 3 months.

☺ 😐 ☹
10 9 8 7 6 5 4 3 2 1

"10" is perfect energy – at 100%!
"1" means you need help just to get out of bed.

When was the last time you felt 100% well?

It's been_____months/ yrs
(circle one)

Activity:
You are physically active for

_____min/ hrs (circle) a day

_____days/week.

Your activity is usually:

Sleep:

What time do you put out the light to sleep?

_____.-

- The TV? _____.

How long does it take you to fall asleep?

_____min/hrs

How many times do you wake during the night? _____

If so, why?

Do you snore? No/ Yes

Do you stop breathing?

No/ Yes

Do you sleep with a person (or pet) who does?

No/ Yes

What time do you get out of bed to start your day?

_____.-

Do you take naps? No/ Yes

- If yes, how often?

- and for how long?

- and how do you feel after waking from your nap?

better - same - worse

Part X: Setting priorities

When you have completed this long, long questionnaire, I will have a pretty good idea about your health problems. Yet, I need your help in setting our goals.

Your top three health goals

Imagine you have rubbed a Magic Lamp and out popped a Genie in a white coat – he's a magic *doctor!*

He offers you the customary 3 wishes – but he only fixes health problems. So, now you get to choose: What are your three biggest problems to be wished away?

Genies can be tricky, so be clear in your wishes and specific about what you want. Please write your 3 wishes on this page.

One last question:

How many doctors have you seen about these problems?

_____.-

This completes the packet of questions we will review at your first visit to the office.

Please use the remaining space to note questions and comments that you wish to discuss at your visit with me.

Thank you for your hard work and all the time you spent completing this.

Samuel L. Moltz, M.D.