Atlantic
Medicine & Wellness

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PATIENT PERSONAL HISTORY FORM

NAME: _____
(PLEASE PRINT)
D.O.B.: ___/___/____
Birth Place: _____
Primary Care Physician: _____
Phone Number: _____
Date of Last Physical:_____/___/_____
List all States and Countries in which you have lived in:
_____ _____ _____
_____ _____ _____

Chief Complaints: (List all symptoms)

1.	2.
3.	4.

Personal History:

Do you Smoke?	No	Yes
Do you Drink?	No	Yes
Beer	No	Yes
Wine	No	Yes
Coffee	No	Yes_____cups/day
Decaffeinated	No	Yes_____cups/day
Tea	No	Yes_____cups/day
Herbal Tea	No	Yes_____cups/day
Juice	No	Yes_____cups/day
Milk	No	Yes_____cups/day
Water	No	Yes_____cups/day
Pop	No	Yes_____cups/day

NAME:_____DOB:____/_ /_____DATE:____/_ /____

Are you on a special diet? (If so, please describe)

_____

_____

X-Rays: Have you had any of these X-RAYS, MRI's, or CAT SCANS in the past year? If so, when?

Chest	No	Yes/When:
Stomach	No	Yes/When:
Colon	No	Yes/When:
Gall Bladder	No	Yes/When:
Back/Neck	No	Yes/When:
Kidney	No	Yes/When:
Extremities	No	Yes/When:
Other:	No	Yes/When:

Immunizations: Have you ever been immunized again:

Small Pox	No	Yes/When:
Tetanus	No	Yes/When:
Polio (shots or oral)	No	Yes/When:
Measles	No	Yes/When:
German Measles	No	Yes/When:
Other	No	Yes/When:

Allergies: Are you allergic to the following?

Penicillin	No	Yes
Sulfa	No	Yes
Other Antibiotics	No	Yes
Any other drug/medicine	No	Yes
Any Food	No	Yes
Nail Polish/Cosmetics	No	Yes
Other		

Weight Loss/Sleep Disorders:

Have you gained weight in the last year? If so, how much? _____

Have you lost weight in the last year? If so, how much? _____

Do you have trouble falling asleep? _____

Do you have trouble staying asleep? _____

NAME:_____DOB:____/_ /_____DATE:____/_ /____

Medicine:

Please list all prescription medicines or drugs you are currently taking, that were prescribed by a Doctor or Dentist. (Include what you take for chronic conditions, birth control, etc.).
*Please indicate strength and quantity taken daily.

1.	2.
3.	4.
5.	6.

Please list over the counter medicines or drugs you may take without a prescription.
(Aspirin, antacids, sleep medicine, etc.)

1.	2.
3.	4.

Please list all vitamins, minerals and/or nutritional supplements that you are now taking.
*Please indicate strength and number taken daily.

1.	2.
3.	4.
5.	6.

Devices: Do you use:

Eyeglasses	No	Yes
Contact Lenses	No	Yes
Hearing Aid	No	Yes
Dentures	No	Yes
Neck Brace	No	Yes
Back Brace	No	Yes
Other Brace	No	Yes
Artificial Limb	No	Yes
Pacemaker	No	Yes
I.U.D.	No	Yes
Diaphragm	No	Yes

NAME:_____DOB:____/_ /_____DATE:____/_ /____

Operations: Have you had any of these operated on?

Tonsils	No	Yes/When:
Appendix	No	Yes/When:
Gall Bladder	No	Yes/When:
Stomach	No	Yes/When:
Small Intestines	No	Yes/When:
Kidney	No	Yes/When:
Colon	No	Yes/When:
Thyroid	No	Yes/When:
Hernia (Rupture)	No	Yes/When:
Angioplasty Bi-Pass	No	Yes/When:
Breast	No	Yes/When:
Uterus	No	Yes/When:
Ovaries	No	Yes/When:
Prostate	No	Yes/When:
Other		

Diagnosed Difficulties: Do you now, or have you in the past had any of the following…

Migraine Headaches	No	Past/When:	Yes/Now
Epilepsy/Convulsions	No	Past/When:	Yes/Now
Stroke	No	Past/When:	Yes/Now
Glaucoma	No	Past/When:	Yes/Now
Cataracts	No	Past/When:	Yes/Now
Blindness	No	Past/When:	Yes/Now
Ear Infections	No	Past/When:	Yes/Now
Deafness	No	Past/When:	Yes/Now
Asthma	No	Past/When:	Yes/Now
Hay Fever	No	Past/When:	Yes/Now
Chronic Bronchitis	No	Past/When:	Yes/Now
Emphysema	No	Past/When:	Yes/Now
Tuberculosis	No	Past/When:	Yes/Now
Other			

NAME:_____DOB:____/_ /_____DATE:____/_ /____

Family History: Has any blood relative ever had: (Please answer the following questions by circling "yes" or "no". Fill in the "who" or "when" information when necessary)

Cancer (including Leukemia)	No	Yes/Who:
Tuberculosis	No	Yes/Who:
Diabetes	No	Yes/Who:
Heart Trouble	No	Yes/Who:
Heart Attack	No	Yes/Who:
High Blood Pressure	No	Yes/Who:
Stroke	No	Yes/Who:
Epilepsy	No	Yes/Who:
Bleeding Disorder	No	Yes/Who:
Asthma	No	Yes/Who:
Allergies	No	Yes/Who:
Liver Disease	No	Yes/Who:
Migraine Headaches	No	Yes/Who:
Alcoholism	No	Yes/Who:
Emphysema	No	Yes/Who:
Stomach/Duodenal Ulcer	No	Yes/Who:
Kidney Disease	No	Yes/Who:
Glaucoma	No	Yes/Who:
Sickle Cell Anemia	No	Yes/Who:
Other Anemia	No	Yes/Who:
Mental Illness	No	Yes/Who:
Suicide	No	Yes/Who:
Birth Defects	No	Yes/Who:
Other Serious Disease	No	Yes/Who:

	Living	Dead	Age at Death	Cause of Death
Father				
Mother				
Siblings				
Spouse				
Children				

NAME:_____DOB:____/_ /_____DATE:____/_ /____

QUESTIONNAIRE AND SCORE SHEET

This questionnaire is designed for adults. It lists the factors in your medical history which may promote the growth of *Candida Albicans* (Section A), and symptoms commonly found in individuals who may have problems with abnormal carbohydrate metabolism, multiple allergies and/or the toxic influence of mercury from silver fillings in the teeth (Section B, C, and D). For each "Yes" answer in Section A, circle the point score in that section. Total your score and record it in the box at the end of the section. Then move onto Section B, C, and D and score as directed. Filling out and scoring this questionnaire will help you and your physician evaluate your health problems. Yet will not provide an automatic "Yes or No" answer for any conditions.

SECTION A: HISTORY	**SCORE**
Have you taken tetracyclines for acne for 2 months or longer?	25
Have you any time in your life, taken other "broad spectrum" antibiotics for respiratory, urinary or other infections for 2 months or longer, or in shorter courses 5 or more times in a 1 year period?	20
Have you taken Prednisone, Decadron or other cortisone-type drugs … For more than 2 weeks?	15
For 2 weeks or less?	6
Does exposure to perfumes, insecticides, fabric shop orders and other chemicals provoke… Moderate to severe symptoms?	20
Mild Symptom?	10
Are your symptoms worse on damp, muggy days or in moldy places?	20
Have you had persistent athlete's foot, dandruff or other chronic fungus infections of the skins or nails?	20

FEMALE PATIENTS ONLY

Have you, at any time in your life, been troubled by persistent vaginal problems Episodes of vaginitis in a year	25
Have you been pregnant? YES / NO	
2 or more times?	10
1 time?	5
Have you taken birth control pills? YES / NO	
For more than 2 years	15
For 6 months to 2 years	8
Vaginal Discharge	10
Vaginal burning or itching	5
Endometriosis	10
Pain with period	10
Premenstrual tension	10
TOTAL SCORE SECTION A	

Are These Currently Occurring? YES / NO

NAME:_____DOB:____/_ /_____DATE:____/_ /____

SECTION B: MAJOR COMPLAINTS

For each symptom which is present, enter the appropriate figure in the Point Score column:

If there are no symptoms……. Score 0 points
If a symptom is mild …… Score 2 points.
If a symptoms is moderate..…….. Score 4 points.
If a symptom is severe or disabling……. Score 6 points.

Add total score for this section and record it in the box at the end of the section. Note: If you do not have the symptom, leave blank.

	SCORE
DO YOU CRAVE SUGAR?	
DO YOU CRAVE BREAD?	
DO YOU CRAVE ALCOHOLIC BEVERAGES?	
DO YOU CRAVE CHOCOLATE?	
DOES TOBACCO SMOKE BOTHER YOU?	
FATIGUE OR LETHARGY	
FEELING OF BEING "DRAINED"	
FEELING OF BEING EXHAUSTED	
POOR MEMORY	
FEELING "SPACEY" OR "UNREAL"	
DEPRESSION	
SUICIDAL THOUGHTS	
NUMBNESS, BURNING OR TINGLING	
PAIN AND/OR SWELLING IN JOINTS	
ABDOMINAL PAIN	
CONSTIPATION	
DIARRHEA	
BLOATING	
LOST OF INTEREST IN SEX	
SPOTS IN FRONT OF EYES	
BLURRED VISION	
TOTAL SCORE SECTION B:	

NAME:_____DOB:____/_ /_____DATE:____/_ /____

SECTION C: ADDITIONAL COMPLAINTS

(Same scoring as Section B)

If there are no symptoms…….. Score 0 points
If a symptom is mild …… Score 2 points.
If a symptoms is moderate…….. Score 4 points.
If a symptom is severe or disabling…… Score 6 points.

*Add total score for this section and record it in the box at the end of this section.

	SCORE
Cry easily	
Crying spells	
Nervous Breakdown	
Constant worries	
Anxiety	
Phobias	
Fainting Spells	
Speech Difficulty	
Tremors	
Cold Sweats	
Inside Trembling	
Staggering	
Convulsions	
Nausea	
Oily Hair	
Allergies	
Easy Bruising	
Chills	
Fever	
Swollen Gland	
Nose Bleeds	
Sinus Trouble	
Mouth Problems	
Tongue Problems	
Tooth Problems	
Root Canals	
Silver Amalgam	
Hoarseness	
Rash	
Yellow Skin	
Changing Mole	
Stiff Neck	
Neck Pain	
Wheezing	
Poor Exercise Tolerance	

NAME:_____DOB:____/_ /_____DATE:____/_ /____

If there are no symptoms…….. Score 0 points
If a symptom is mild …… Score 2 points.
If a symptoms is moderate…….. Score 4 points.
If a symptom is severe or disabling…… Score 6 points.

	SCORE
Heart Pounding	
Heart Flutter	
Fast Heart Beat	
Chest Pain	
Frequent Cough	
Night Sweats	
Swollen Ankle	
Pain on urination	
Up to urinate at night	
Urinary Incontinence	
Urinary Frequency	
Urinary Urgency	
Burning Urination	
Back Pain	
Leg Cramps	
Cold	
Too Warm	
Thirsty	
Difficulty Swallowing	

MALE PATIENTS ONLY	**SCORE**	**FEMALE PATIENTS ONLY**	**SCORE**
Difficulty having erections		Breast Lumps	
Lump in Testicle		Discharge from Nipple	
Sore on Penis		Vaginal Spotting	
Discharge from Penis		Hot Flashes	
Breast Lump		Pain with Intercourse	
Impotence		Pelvic Pain	
TOTAL SCORE SECTION C:		**TOTAL SCORE SECTION C:**	

NAME:_____DOB:____/_ /_____DATE:____/_ /____

If there are no symptoms…….. Score 0 points
If a symptom is mild …… Score 2 points.
If a symptoms is moderate…….. Score 4 points.
If a symptom is severe or disabling…… Score 6 points.

SECTION D: OTHER SYMPTOMS

*Add total score for this section and record it in the box at the end of this section.

	SCORE
Jitteriness	
Irritability	
Incoordination	
Inability to Concentrate	
Frequent Mood Swings	
Headache	
Dizziness/Loss of Balance	
Pressure above Ears	
Itching	
Other Rashes	
Heartburn	
Indigestion	
Belching	
Intestinal Gas	
Mucous in Stool	
Hemorrhoids	
Dry Mouth	
Rash or blisters in mouth	
Bad Breath	
Joint swelling or Arthritis	
Nasal Congestion	
Nasal Discharge	
Postnasal Drip	
Nasal Itching	
Sore or Dry Throat	
Cough	
Pain or tightness in Chest	
Wheezing	
Shortness of Breath	
Failing Vision	
Burning or tearing of eyes	
Recurrent ear infections	
Fluid in Ears	
Ear Pain	
Wax in Ears	
Deafness	
Tubes in Ears	
Drowsiness	
Insomnia	
Nightmares	
TOTAL SCORE SECTION D:	

*While the symptoms in this section occur commonly in patients with yeast-connected illness, they also occur commonly in patients who have allergies, chronic viral infections (i.e. Mononucleosis, Cytomegalovirus, Epstein Barr) mercury toxicity from fillings in the teeth, diabetes, low blood sugar and chronic fatigue syndrome.

NAME:_____DOB:____/_ /_____DATE:____/_ /____

Total score from Section A: _____

Total score from Section B: _____

Total score from Section C: _____

Total score from Section D: _____

GRAND TOTAL SCORE (Add up total scores from Section A, B, C and D:

_____