"solving the root cause"

cam Center For Advanced Medicine
Medical Clinic

Subjective Questionnaire

Patient Name _____ Today's Date_____ Birth Date_____

Prinicpal complaint(s)_____

Check the following boxes where applicable: 1 = mild or occasional 2 = moderate
3 = severe or nearly constant P = problem in past

	1	2	3	P
GENERAL				
Fever				
Pain / aching:				
Where:				
Describe (sharp, dull etc.):				
How long:				
Under what conditions:				
Fatigue				
Under what conditions:				
How long:				
Swollen glands				
General weakness				
Frequent colds or infections				
SKIN				
Cuts heal slowly				
Bruise easily				
Rash				
Eczema, psoriasis				
Pigmentation / brown spots				
Fungus infection on toes or elsewhere				
Changing moles				
Acne / pimples				
Nails split or ridged				
Crawling sensation				
Burning on bottom of feet				
Peeling or cracking skin on feet				
Other skin problems				
HEAD				
Poor concentration				
Confusion				
Headaches				
Where (front, back, etc.):				
When (after eating, morning, etc.):				
Mental sluggishness				
Poor memory / forgetfulness				
Indecisive				
Face twitch				
Hair loss				
Head pressure				
EARS				
Pain / aching in ears				
Ear infections				
Ringing / buzzing				
Itcing in ear canal				
Itcing and redness when wearing earrings				
Deafness				

	1	2	3	P
NOSE AND SINUSES				
Stuffy / blocked nose				
Runny nose				
Sinus infection				
Nasal polyps				
Sinus pain				
MOUTH				
Bad breath				
Coated tongue				
Sore tongue				
Bleeding gums				
Canker sores				
THROAT				
Need to clear throat / mucus				
Difficulty swallowing				
Hoarseness				
Tonsilitis				
Soreness				
Enlarged glands				
NECK				
Stiffness				
Swelling				
Lumps				
CIRCULATION				
Swollen ankles				
Sensitive to heat				
Sensitive to cold				
Extremities cold or clammy				
Hands and feet go to sleep / numb				
High blood pressure				
Low blood pressure				
Chest pain				
Dizziness on arising				
Dizziness, faintness				
High cholesterol				
Numbness				
Irregular or pounding heartbeat				
Abnormal electrocardiogram (EKG)				
Angina (heart / chest pain)				
Enlarged heart				
Heart murmur				
Phlebitis				
Swollen glands				
Difficulty sweating				
Night sweats				
Varicose veins				

Subjective Questionnaire

Patient Name _____

	1	2	3	P
EYES				
Gritty feeling in eyes / dry eyes				
Blurred vision				
Double vision				
Poor night vision				
Bright flashes				
Halos around lights				
Eye pains				
Dark circles under eyes				
Sensitive to sunlight or strong light				
Wear sunglasses				
Watery eyes				
Cataracts				
Floaters in eyes				
Blindness				
Glaucoma				
GASTROINTESTINAL / DIGESTION				
Ulcers				
Poor appetite				
Excessive appetite				
Gallbladder attacks or stones				
Nervous stomach				
Sweets upset				
Indigestion				
Heartburn				
Nausea				
Vomiting				
Vomiting blood				
Abdominal pains or cramps				
Bloating / abdominal distention				
Gas				
Diarrhea				
Constipation				
Alternating constipation and diarrhea				
Bowel habit changes				
Rectal bleeding				
Tarry stools				
Laxatives used often				
Incomplete bowel evacuation				
Colon or bowel trouble				
Abnormal stomach x-ray				
Appendicitis				
Rectal itch				
Hemorrhoids				
KIDNEYS / URINARY TRACT				
Burning urination				
Frequent urination				
Blood in urine				
Cloudy urine				
Nighttime urination				
Problem passing urine				
Trouble controlling urine / incontinence				
Kidney pain (mid-back)				
Kidney stones				
Kidney infection				

	1	2	3	P
REPRODUCTIVE / GENITALIA				
Male:				
Lump in testicles				
Sore on penis				
Penis discharge				
Erection problem				
Diminished sex desire				
Hernia				
Female:				
Fibroids in breasts				
Breast lumps				
Nipple discharge				
Vaginal itching				
Vaginal discharge				
Non-period bleeding, spotting				
Hot flashes				
Diminished sex desire				
Pain with intercourse				
Change in periods				
Pain other than with periods				
Endometriosis				
Menstrual cramps				
Possible pregnancy				
Infertilitiy, difficulty getting pregnant				
STRUCTURAL				
Head injury				
Concussion				
Whiplash				
Neck stiffness				
Low back stiffness				
Joint pains				
Joint swelling				
Muscle weakness				
Muscle lumps / swelling				
Muscle stiffness				
Bump on bones				
Damp weather causes aching				
Mobility problems				
Tightness or pain between shoulder blades				
Feel like head is in front of body				
Harder to move neck in one direction				
Wallet in hip pocket habitually				
Heavy purse over shoulder habitually				
Body or face not symmetrical				
Pain or popping in jaw				
Other structural injury:				
RESPIRATION				
Wheezing				
Low exercise tolerance				
Frequent coughing				
Cough up blood				
Pain when breathing deeply				
Breathing heavily				
Sigh frequently				
Abnormal chest x-ray				

Subjective Questionnaire

Patient Name _____

	1	2	3	P
RESPIRATION CONT.				
Asthma				
Chronic bronchitis				
Emphysema				
Shortness of breath				
Tuberculosis				
NUTRITIONAL				
Craving for sweets, fruit				
Craving for vinegar, ketchup				
Craving for bread, starches, pasta				
Craving for fatty foods				
Craving for spicy foods				
Craving for salt				
Craving for coffee / tea / cola				
Craving for alcohol				
Other cravings - type:				
Abnormal thirst				
Sleepy after meals				
Food allergy, proven or suspected				
Pulse speeds, after meals				
Irritable before meals				
Hungry soon after meal				
Poor smell / taste				
Appetite loss, anorexia				
White spots on nails				
Weight gain				
Difficulty losing weight even on diet				
Weight loss				
Difficulty gaining or maintaining weight				
Bulimia (binge / purge)				
Take vitamins				
PSYCHOLOCIAL				
Feeling that life is unsatisfactory				
Feeling that life is boring				
Feeling that life is demanding and stressful				
Worry about home life, relationship, children				
Worry about health				
Worry about job, income, money				
Depression				
Anxiety				
Phobias, irrational fears				
Irritability				
Anger				
Shyness, timidity				
Cry often or easily				
Feel inferior				
Have you considered suicide				
Have you attempted suicide				
PERSONAL HABITS				
Smoke _____packs a day				
Quit smoking _____years ago				
Chew tobacco				
Cofee _____cups a day				
Drink alcohol				
Recreational drugs - type:				
Use cologne / perfume / scented products				

	1	2	3	P
PERSONAL HABITS CONT.				
Wear nail polish / acrylic nails				
Use cosmetics				
Get regular exercise				
NEURO-MUSCULAR				
Can't go to sleep				
Can't stay asleep				
Sleep too much				
Speech problem				
Leg or arm weakness				
Balance problems				
Muscle cramping				
Shaking, twitching				
MEDICAL PROBLEMS NOT COVERED ELSEWHERE				
AIDS				
Anemia				
Arthritis				
Boils				
Broken bones				
Cancer				
Cirrhosis of the liver				
Diabetes				
Gout				
Goiter				
Gonorrhea				
Hay fever				
Heart attack				
Hepatitis				
Monoculeosis				
Nervous breakdown				
Obesity				
Parasites				
Poor blood clotting				
Polio				
Rhematic fever				
Stroke				
Syphilis				
Thyroid overactive				
Thyroid underactive				
Warts				
Yeast infection, thrush				
MEDICATIONS TAKEN (1 = occasionally, 3 = often)				
Antibiotics				
Insulin				
Steroids, cortisone, Prednisone				
Thyroid medication				
Heart / blood pressure medication				
Hormones, birth control pills, estrogen				
Antacids				
Other:				
SURGERIES, ORGANS REMOVED (list)				

Subjective Questionnaire

Patient Name _____

ALLERGIES / SENSITIVITIES	1	2	3	P
Pollen				
Mold				
Foods				
List:				
Carpet / furniture / cabinets				
Pesticides, fumigation				
Smoke				
Chemicals				
Penicillin				
Sulfa drugs (antibiotics)				
Aspirin				
Medications				
Dust				
Fabric				
Metals				
Cologne, scented products				
Cologne smells like bug spray				
Suspect you're allergic but don't know to what				
Other allergies:				
BIRTH FACTORS - WERE YOU:				
Cesarean section				
Premature				
Forceps delivery				

BIRTH FACTORS - WERE YOU: (cont)	1	2	3	P
Bottle fed				
Breast fed				
Birth Trama (describe)				
DENTAL				
Metal amalgam fillings				
If removed, when:				
Root canals				
Bridges in mouth				
Crowns / caps				
Material used:				
Braces / retainer				
Sensitive teeth				
Metal elsewhere in body (pins, staples):				
ELECTROMAGNETIC RADIATION				
Live under or near power lines				
Work with computers				
Use a waterbed or electric blanket				
Use a cellular or portable phone				
Frequent x-rays				
Other radiation exposure				
Describe:				

Briefly describe where you have lived since childhood - part of country / world, in city / rural etc.

Describe your work history - include exposure to chemicals, fumes, pesticides, metals, heavy lifting, electro-magnetic and other radiation, sick patients, asbestos, high stress, and anything that may be health related.

Dates: Description of work:

Dates: Description of work:

Dates: Description of work:

Describe your hobbies, sports, and forms of recreation, with attention to exposure as listed under work history:

Is there anything else you would like us to know?