MIDATLANTIC HEALTH PATIENT INVENTORY FORM

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APPT DATE:_____ REF BY: _____

Patient Name : _____

Date of Birth:_____

Address: _____

Phone Number:_____

Email Address:_____

1. **CC: What are your biggest complaints and symptoms?**

2. **PRIOR DIAGNOSES and PROVIDERS?**

3. **PRIOR LABS**
    a. **Labcorp/Quest**
    b. **Specialty labs (igenex, fry labs)**

4. **PRIOR TREATMENTS AND MEDICATIONS:**

5. **GENERAL IMPACT ON LIFESTYLE**

6. **HOW LONG HAS IT BEEN SINCE YOU WERE WELL? WERE THERE ANY TIMES DURING PAST TREATMENT YOU DID FEEL BETTER?**

7. **WHEN DID YOUR PROBLEMS BEGIN AND HOW DID THEY PROGRESS?**

8. **PAST MEDICAL HISTORY: circle all and add if not listed**

asthma	allergies	arthritis	anx/dep	cancer	celiac/gluten	diabetes
ChrFatigue	fibromyalgia	HA/migraine	high BP	high chol	kidney dz	liver dz
lupus	lyme	mono	rheumatoid arthritis	seizures	skin/eczema	stroke
thyroid high or low						

9. **PAST SURGICAL HISTORY:**

10. **PAST INJURIES: (sprains, fractures, concussions, significant wounds)**

11. **HOSPITALIZATIONS:**

12. ALLERGIES, SENSITIVITIES, REACTIONS to drugs, herbs,supplements -

MED/SUPPLEMENT	TYPE OF REACTION

13. ALLERGIES to animals, foods, environment, chemical sensitivities? list below

ANIMALS: _____
FOODS: _____
ENVIRONMENT: _____
CHEMICALS: _____

14. **CURRENT MEDICATIONS: (or attach)**

15. CURRENT SUPPLEMENTS: (or attach)

16. **DATE OF LAST EXAM and PROVIDER:_____**

17. **KNOWN MOLD EXPOSURES:_____**

18. **PRIOR DIAGNOSTIC TESTING:**

TEST	RESULT
colonoscopy	
CTScan	
MRI	
EKG/Stress test	
other	

19. **FAMILY History - please circle any significant**
    - **asthma, allergies, cancer, high BP, high chol, heart disease, celiac, thyroid, diabetes, rheumatoid arthritis, IBS/IBD, seizure**

20. Pain

Location	Burning	Stabbing	Aching

Average daily pain score 0-10 (worst):_____

DAILY ROUTINE AND LIFE STRESSES:

- **DIETARY HX -**
(restrictions? organic? clean? sensitivities? balanced protein/carb/fat?)

- **ACTIVITY HX - please tell us what activities you enjoy, how often, and if your exercise routine has changed?**

- **STRESS and LIFE MANAGEMENT - please briefly describe any major life stressors; significant relationships - married/single, children; job/professional life**

- **SLEEP - Please describe any trouble falling asleep? staying asleep? snoring or sleep apnea? daytime fatigue?**

REVIEW OF SYSTEMS - circle any that apply, past or present

SYMPTOM	PAST	PRESENT
allergies		
chronic nasal congestion		
asthma		
BP - high or low		
Dizziness		
palpitations		
fatigue w exercise		
shortness of breath		
trouble w sleep		

SYMPTOM	PAST	PRESENT
HA/migraines		
weight - gain or loss		
appetite - up or down		
cold or heat intolerance		
constipation		
gas or belching		
nausea/heartburn		
diarrhea		
mouth ulcers		
jaw pain or TMJ		
vision sx		
night blind		
irregular menses (females)		
yeast infections		
loss of libido		
bladder infections/UTIs		
kidney stones		
anemia		
bleeding problems		
history of MONO		
unexplained fevers		
swollen glands		
frequently sick - URI, flu		
eczema		
acne		
Skin itching or crawling		

SYMPTOM	PAST	PRESENT
rashes		
hair loss		
back or neck pain		
joint pains		
muscle aches		
head injury		
numb/tingling		
brain fog		
memory issues		
concentration issues		
bells palsy		
speech difficulty		