IN AVANTI HEALTH

HEALTH & LIFESTYLE QUESTIONNAIRE

All information you provide in this questionnaire will be treated as private and confidential. It will only be released to other individuals with your written permission. Thank you for answering all questions completely and honestly.

Name _____ Date of Birth _____ Age _____ Sex _____

Address _____ City/State/Zip _____

Home phone _____ Work phone _____ Cell phone_____
Email _____

Occupation / Employer _____
Marital Status: □ single □ married □ divorced □ widowed □ partnered □ separated
Spouse or partner's name _____ Ages of children _____
What is the best time and method to get in touch with you? _____
What is your height _____ Weight _____ Desired weight _____

Referred by: _____

A successful healthcare team includes a patient who is committed to making and maintaining needed changes and a compassionate, dedicated physician who thoroughly understands the patient physically, mentally and emotionally.

Please list your main health concerns in order of importance, including onset, whether it is accident related and the types of treatment you've had for each:

Concern	Onset	Current and/or Past Treatment
1.		
2.		
3.		
4.		
5.		

Date of last physical exam: _____ Practitioner name and phone #: _____

Please list all drug allergies: (specify if "none")

Please list any non-drug allergies/sensitivities you experience such as food allergies, environmental, animals, etc.:

Specify all medications you are currently using: (include hormones and non-prescription medicines)

Name_____ Dose_____ Times/Day_____

Name_____ Dose_____ Times/Day_____

Name_____ Dose_____ Times/Day_____

Name_____ Dose_____ Times/Day_____

List all hospitalizations and surgical procedures you have had (with dates) – include cosmetic surgery:

Are you currently receiving alternative or "natural" therapies:

- ☐ chiropractic
- ☐ acupuncture
- ☐ therapeutic massage
- ☐ homeopathy
- ☐ colonics
- ☐ chelation
- ☐ kinesiology
- ☐ juicing
- ☐ herbal (specify _____)
- ☐ other _____

Have you been exposed to potentially harmful chemicals, metals, or radiation at home or at work? (for example – dental fillings, pesticides, radioactivity, solvents, glues)

_____Exposed to:_____When Exposed:_____How Exposed:_____

Do you have any adverse (or opposite) reactions to medications? ○ Yes ○ No If yes, please explain:

Do you have to reduce the recommended doses of medications to avoid adverse reactions? ○ Yes ○ No

Tobacco use: Type smoked/chewed _____ Amount per day _____Age started _____
Age stopped ___

Are you exposed to tobacco at home? ○ Yes ○ No At work? ○ Yes ○ No

Alcohol consumption: Drinks/week _____ Typical beverages _____

Coffee: 6 oz cups/day _____ Caffeinated Tea: 6 oz cups/day_____

Does coffee strongly affect you? ☐ Yes ☐ No What reactions do you have? _____

Caffeinated Soda: 12 oz cans/day _____ Diet soda: 12 oz cans/day _____

Water: 8 oz glasses/day _____ What type? ☐ Bottled ☐ Purified water ☐ Tap ☐ Well

Recreational Drug Use _____

Exercise:

☐ 5-7 days/week
☐ 3-4 days/week
☐ 1-2 days/week
☐ 45 minutes or more/workout
☐ 30-45 minutes/workout
☐ Less than 30 minutes/workout

☐ Walk
☐ Run, jog, jump rope
☐ Weight lift
☐ Swim
☐ Yoga
☐ Other: _____

Nutrition Summary:

☐ Mixed food diet (animal and vegetable sources)
☐ Vegetarian
☐ Vegan
☐ Salt restriction
☐ Fat restriction

☐ Starch/carbohydrate restriction
☐ Total calorie restriction
☐ Other: _____
Specific food restrictions:
☐ dairy ☐ wheat ☐ eggs ☐ soy
☐ corn ☐ all gluten ☐ other: _____

Which fats do you use? ☐ Margarine ☐ Butter ☐ Olive oil ☐ Flax ☐ Safflower ☐ Coconut ☐ Sunflower ☐ Corn ☐ Shortening ☐ Canola ☐ Peanut ☐ Soybean ☐ Mayonnaise

Do you crave:
- sugar and sweets ○ Yes ○ No
- breads and pasta ○ Yes ○ No
- chocolate ○ Yes ○ No
- salty foods ○ Yes ○ No
- fatty foods ○ Yes ○ No
- other _____

Food Frequency:

Servings per day or per week:
Fruits: _____
Dark green or deep yellow/orange vegetables: _____
Grains (unprocessed): _____
Beans, peas, legumes: _____
Dairy, eggs: _____
Meat, poultry: _____
Nuts, seeds: _____

How many times a week do you eat fish? What kinds? _____

How many times a week do you eat out? _____

List the three worst foods you eat during an average week: _____

List the three healthiest foods you eat during an average week: _____

Eating Habits:

☐ Skip breakfast
☐ Two meals/day
☐ One meal/day
☐ Graze (small frequent meals)

☐ Food rotation
☐ Eat constantly whether hungry or not
☐ Generally eat on the run
☐ Add salt to food

Please list any vitamins, herbs, or other supplements you currently take: (use additional page if necessary)

Rate your stress level on a scale of 1-10 during the average week: _____

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):

_____

Have you had an unintentional weight loss or gain or 10 pounds or more in the last three months?

_____

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disease (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Obesity
- ☐ Osteoporosis/osteopenia
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other:

_____

Medical (MEN)

- ☐ Benign prostatic hypertrophy (BPH)
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Erectile dysfunction
- ☐ Infertility
- ☐ Sexually transmitted disease

Other:

_____

Medical (WOMEN)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other: _____

Age at first period: _____

Date of last gynecological exam: _____

Mammogram ☐ + ☐ -

PAP ☐ + ☐ -

HPV ☐ + ☐ -

Form of birth control: _____

# of children: _____

# of pregnancies: _____

- ☐ C-section
- ☐ Surgical menopause

Date of last menstrual cycle: _____

Length of cycle: _____days

Interval of time between cycles: _____days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty): _____

Family Health History (Grandparents, parents and siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disease (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide
- ☐ Thyroid Disease

Other:

_____

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of or reduce pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get fewer colds and flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)