APPLIED INGENUITY DIAGNOSTICS

Name: _____

Date of Birth: _____ Gender: □ Male □ Female

Address: _____

Past Medical History: *(check all that apply)*

□ Acid Reflux
□ Alcohol or Drug Problem
□ Allergy Problems
□ Anemia
□Anxiety
□ Artery/Vein problems
□ Arthritis
□ Asthma
□ Autoimmune Disease
□ Bleeding problems
□ Blood clots
□ Cancer
□ Cataracts
□ Colitis/Crohn's
□ Chronic pain
□ Depression
□ Diabetes
□ Esophagitis, ulcers
□ Fractures
□ Gallstones
□ Glaucoma
□ Gout
□ Headaches
□ Heart Disease
□ Heart Valve problems
□ High blood pressure
□ High cholesterol
□ HIV
□ Irritable bowel
□ Kidney disease
□ Kidney stones
□ Liver disease/ Hepatitis
□ Lung disease
□ Migraines
□ Mental Health Diagnosis
□ MRSA
□ Osteoporosis
□ Recurrent Skin Infections
□ Recurrent UTI
□ Seizures
□ STIs
□ Sleep Apnea
□ Stroke
□ TB
□ Thyroid disease

Other Medical History:

_____

_____

_____

_____

_____

Hospitalizations/Significant injuries: _____

_____

_____

_____

Surgery/Procedures History: *(check all that apply)*

□ Appendix
□ Bladder Suspension
□ Blood vessel surgery
  □ Arteries
  □ Veins
□ Colon/Rectal surgery
□ Eye surgery
□ Gallbladder
□ Heart Surgery
□ Bypass
□ Heart valve surgery
□ Angioplasty (balloon)
□ Stents
□ Pacemaker
□ Hysterectomy
  □ Complete □ Partial
□ Hernia
□ Joint replacement/Orthopedic surgery
□ Kidney surgery
□ Organ Transplant
□ Prostate surgery
□ Thyroidectomy
□ Sinus surgery
□ Tonsils and/or adenoids
□ Tubal Ligation
□ Vasectomy

Other surgery not listed above: _____

_____

Current Medications

Please list any medications that you are now taking. Including non-prescription medications & vitamins or supplements:

Medication	Dosage	How Often	How long have you been taking this medication?	Disease or Reason

List all medications you have stopped taking within the last 12 months: _____

_____

_____

Allergies and Reactions

Medication/Food/ Environmental	Reaction	Medication/Food/ Environmental	Reaction

Family Medical History ☐ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

Check All That Apply	Alcohol/Drug Abuse	Asthma	Cancer	Anemia	Depression/Anxiety	Liver Disease	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Hepatitis	Other:	Other:	Other:
Mother																			
Father																			
Brother																			
Sister																			
Child																			
Maternal Grandmother																			
Maternal Grandfather																			
Paternal Grandmother																			
Paternal Grandfather																			
Other:																			

Social History

Do you live: ☐ Alone ☐ with Spouse or Partner ☐ with Family ☐ Other

What is your current or past occupation? _____

Do you smoke? ☐ Yes ☐ No ☐ Previously in the past _____ packs/day for _____ years Date quit: _____

Other Nicotine use? ☐ Yes ☐ No Exposure to second hand smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No ☐ Beer ☐ Wine ☐ Liquor How many drinks per week? _____

How many caffinated beverages per day? _____ ☐ Coffee ☐ Tea ☐ Soda ☐ Other: _____

Any recreational drug use? ☐ Yes ☐ No Type: _____

Do you exercise regularly? ☐ Yes ☐ No If so how many times per week? ____ Type of exercise: _____

Do you feel safe in your home? ☐ Yes ☐ No How many hours of sleep do you get per night? _____

SYSTEMS REVIEW

In the past month, have you experienced any of the following problems?

GENERAL
□ Recent weight gain; how much____
□ Recent weight loss: how much____
□ Fatigue
□ Weakness
□ Fever
□ Night sweats

MUSCLE/JOINTS/BONES
□ Numbness
□ Joint pain
□ Muscle weakness
□ Joint swelling
Where? _____
_____

EARS
□ Ringing in ears
□ Loss of hearing

EYES
□ Pain
□ Redness
□ Loss of vision
□ Double or blurred vision
□ Dryness

THROAT
□ Frequent sore throats
□ Hoarseness
□ Difficulty in swallowing
□ Pain in jaw

HEART AND LUNGS
□ Chest pain
□ Palpitations
□ Shortness of breath
□ Fainting
□ Swollen legs or feet
□ Cough

NERVOUS SYSTEM
□ Headaches
□ Dizziness
□ Fainting or loss of consciousness
□ Numbness or tingling
□ Memory loss

STOMACH AND INTESTINES
□ Nausea
□ Heartburn
□ Stomach pain
□ Vomiting
□ Yellow jaundice
□ Increasing constipation
□ Persistent diarrhea
□ Blood in stools
□ Black stools

SKIN
□ Redness
□ Rash
□ Nodules/bumps
□ Hair loss
□ Color changes of hands or feet

BLOOD
□ Anemia
□ Clots

KIDNEY/URINE/BLADDER
□ Frequent or painful urination
□ Blood in urine

WOMEN ONLY:
□ Abnormal Pap smear
□ Irregular periods
□ Bleeding between periods
□ PMS

PSYCHIATRIC
□ Depression
□ Excessive worries
□ Difficulty falling asleep
□ Difficulty staying asleep
□ Difficulties with sexual arousal
□ Poor appetite
□ Food cravings
□ Frequent crying
□ Sensitivity
□ Thoughts of suicide / attempts
□ Stress
□ Irritability
□ Poor concentration
□ Racing thoughts
□ Hallucinations
□ Rapid speech
□ Guilty thoughts
□ Paranoia
□ Mood swings
□ Anxiety
□ Risky behavior

OTHER PROBLEM: _____
_____
_____
_____
_____
_____
_____