Dr. Nancy Doreo, **DC CABNN DCN DCBCN**
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Science Based Nutrition
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FEMALE MEDICAL HISTORY (for women only)

OBSTETRICS HISTORY *Check box if yes and provide number of*

❑ Pregnancies ____________ ❑ Caesarean ______________ ❑ Vaginal deliveries ________

❑ Miscarriage _____________ ❑ Abortion ________________ ❑ Living Children __________

❑ Post partum depression ❑ Toxemia ❑ Gestational diabetes

❑ Baby over 9 pounds ❑ Breast feeding For how long?___________________________

GYNECOLOGICAL HISTORY

Age at 1st period:______ Menses Frequency: ______ Length: _________ Pain: Yes____ No ____

Clotting: Yes _____ No _____ Has your period skipped? _______ For how long? _______________

Last Menstrual Period: ________

Do you currently use contraception? Yes _____ No _____ If yes, what type do you use?

❑ Condom ❑ Diaphragm ❑ IUD ❑ Partner vasectomy

Have you ever used hormonal contraception? Yes ____ No ____ If yes, when _________________________

Use of hormonal contraception: ❑ Birth control pills ❑ Patch ❑ Nuva Ring How long?_______

Are you using the pill now? Yes ____ No _____ Did taking the pill agree with you? Yes _____ No _____

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, headache, cravings, or irritability (PMS)? ❑ Yes ❑ No

Last Mammogram /Thermogram__________________ Breast Biopsy? Date ___________Result____________

Last PAP Test: ___________________________ Normal ______________ Abnormal ______________

Date of last Bone Density: ______________ Results: ❑ High ❑ Low ❑ Within normal range

Are you in menopause? Yes _____ No _____ Age at Menopause __________Surgical Menopause?___________

Do you take: ❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin Other ____________

❑ Progesterone ❑ Provera Other _____________________________________

How long have you been on hormone replacement? ____

MALE MEDICAL HISTORY

Have you had a PSA done?
Yes _____ No _____

PSA Level:

- ❑ 0 – 2
- ❑ 2 – 4
- ❑ 4 – 10
- ❑ >10

- ❑ Prostate enlargement
- ❑ Prostate infection
- ❑ Change in libido
- ❑ Impotence
- ❑ Diminished/poor libido
- ❑ Infertility
- ❑ Lumps in testicles
- ❑ Sore on penis

- ❑ Genital pain
- ❑ Hernia
- ❑ Prostate cancer
- ❑ Low sperm count
- ❑ Difficulty obtaining erection
- ❑ Difficulty maintaining an erection
- ❑ Nocturia (urination at night)
  - ❑ How many times at night? ____

- ❑ Urgency/Hesitancy/Change in Urinary Stream
- ❑ Loss of bladder control
- ❑ Sweat attacks

Other:_______________________________

General Health

- ❑ Chronic Fatigue
- ❑ Shortness of Breath
- ❑ Headaches
- ❑ Bone Pain
- ❑ Memory
- ❑ Blood Type: O, A, B, AB
- ❑ Autoimmune Disease ______________
- ❑ Chronic Illness____________________

Family Medical History

- ❑ Breast or other Cancers
- ❑ Cardiovascular Disease
- ❑ Stroke/Aneurysm
- ❑ Osteoporosis
- ❑ Obesity
- ❑ Alcoholism
- ❑ Mental Illness/Depression
- ❑ Alzheimer's Diabetes
- ❑ Arthritis

Lifestyle and Diet

Rate your level of Stress on a scale of 1 to 10 (1 is lowest) ___________ Identify major stressors____

Smoke: How much per day______ Drink Coffee/Tea: per day_______ Alcohol Intake: preference____________How much per week________ Exercise, minutes per week___________

Do You Eat:

- ❑ Sweets
- ❑ Sodas
- ❑ Ice Cream
- ❑ Cookies
- ❑ Cakes
- ❑ Fried Foods
- ❑ Whole Grains
- ❑ Legumes
- ❑ Cereals
- ❑ Animal Protein
- ❑ Dairy/Cheese
- ❑ Gluten
- ❑ Salt
- ❑ Fat
- ❑ Fiber
- ❑ Vegetarian
- ❑ Vegan
- ❑ Other___________

Any other family history we should know about? Yes _____ No _____
If yes, please comment: ____

MEDICATIONS & SUPPLEMENTS

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

	< 5 times	**> 5 times**
Infancy/Childhood		
Teen		
Adulthood		

STEROID USE

Oral Steroids: How often have you taken oral steroids (e.g. Prednisone, Cortisone, etc.)?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

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Indicate any medications you're currently taking or have taken in the last month:

- ❑ Acid Blocking Drugs
- ❑ Anti-anxiety medications
- ❑ Antibiotics
- ❑ Anticonvulsants
- ❑ Antidepressants
- ❑ Anti-fungals
- ❑ Aspirin/Ibuprofen
- ❑ Asthma inhalers
- ❑ Beta blockers
- ❑ Birth control pills/implanted contraceptives
- ❑ Chemotherapy
- ❑ Cholesterol lowering medications
- ❑ Cortisone/steroids
- ❑ Diabetic medications/insulin
- ❑ Diuretics
- ❑ Estrogen or progesterone (pharmaceutical, prescription)
- ❑ Estrogen or progesterone (natural)
- ❑ Heart medications
- ❑ High blood pressure medications
- ❑ Laxatives
- ❑ Relaxants/Sleeping pills
- ❑ Testosterone (natural or prescription)
- ❑ Thyroid medication
- ❑ Acetaminophen (Tylenol)
- ❑ Ulcer medications
- ❑ Sildenafil citrate (Viagra or similar)

MEDICATION LOG

Please indicate the type of medications you are taking now. Please include non-prescription drugs.

Medication Name	Date started	Dated Stopped	Dosage	# per day

SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name/Brand	Dose	Frequency	Dated Started	Reason for use

Have your medications or supplements ever caused you unusual side effects or problems?

Yes ____ No _____ If yes, please describe:____

____

ALLERGIES

Medication/Supplement/Food	Reaction
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
	____________________________________

What is the attitude of those close to you about your illness? ❑ Supportive ❑ Non-supportive

What experience have you had with a chiropractor in the past?

____

Is there anything we should be careful of with when it comes to applying physical therapy or chiropractic adjustments to your body?

____

Is there anything else you have tried in order to help yourself get better, and failed?

____

____

What do you hope to achieve in your visit here? ___________________________________

____

If you had a magic wand and could erase three problems, what would they be?

1. ____

2. ____

3. ____

Have you made the decision to change? To do what it takes to get well?

Yes____________ **No**____________

I have read something interesting: ***"The definition of insanity is to keep doing the same thing and expecting different results".*** If you keep following the same course of treatment you have been following will your results really change? Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination.

Most people I ask tell me they've made the decision to change. But how many people have truly

decided to change? Very few! Why? Because there is a big difference between deciding something and having "reasons" to actually do it.
When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:

List up to 5 things that you have *been unable* to do as a result of your present symptoms. Please be specific. (Use extra pages if necessary)

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List up to 5 things that you plan to do once you are feeling better. Please be specific. (Use extra pages if necessary)

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Are there any other health goals you want to achieve?

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As your health care partner, we promise to cooperate with your other health care providers, as you desire. We understand that you are responsible for your own health and outcome according to your level of participation. We expect you to communicate your thoughts, feelings and questions as needed, and we will address each to the best of our ability. Our intentions are for your best interest and outcome. Now, Let's get started!

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