Roxanne Hollander, D.C.

Integrative Functional Medicine

90 Launis Street
Pittsboro, NC 27312
919-542-0325

Date: ____________________

Contact Information

Name____Age__________Birthdate____________

Address_______________________________________Phone____________________________

City____________________________State_________________Zip_______________________

Email:____

Occupation___________________________ How Long ____________Full or part time_________

Emergency contact_________________________________Emergency Phone________________

Marriage Status ________________How many people do you live with? ______________________

Who referred you to this office? ____

List of other physicians or health practitioners: _______________________________________
____
____
____

II. Your Current Health Problems or Limitations

In your opinion, what are your most important health problems? List as many as you can, in order of importance: If possible, note when each began.

1.__________________________________ 5.____
2.__________________________________ 6.____
3.__________________________________ 7.____
4.__________________________________ 8.____

What do you think causes or has caused your ailments or complaints?
____
____
____

III. Your Health History

The general state of my health has been: Excellent__Good__Fair__Poor__

What is your blood type? (A/B/O)________________________________

Have you had any experiences (traumatic or otherwise) that you feel still affect you deeply? ______

Explain, if you wish ____

____

____

What childhood illnesses have you had?

Disease	When	Disease	When
Rubella (3 day-measles)	______	Mumps	_______
Measles (2 week)	______	Chicken pox	_______
Whooping Cough	______	Asthma	_______
Scarlet fever	______	Polio	_______
Rheumatic fever	______	Other	_______

If you had any of the following tests or immunizations, place an X on the appropriate line,
And give the last year you had them if possible:

Test	Year	Vaccine	Year
Chest x-ray	_____	Smallpox	_____
Kidney x-ray (Pyelogram)	_____	Tetanus	_____
Upper GI series	_____	Polio	_____
Colon x-ray (Barium enema)	_____	Typhoid	_____
Gallbladder X-ray	_____	Flu Type?______________________	
EKG	_____	Mumps	_____
TB test	_____	Measles	_____
Other x-rays ____________________		Rubella	_____
____________________		Diphtheria	_____
____________________		Other	_____

Please check the appropriate column (or columns):

Condition	Now	Past	Never	Condition	Now	Past	Never
AIDS				Gout			
Alcoholism				Heart Condition			
Allergies				Herpes			
Anemia				HBP			
Arthritis				Injury (serious)			
Asthma				Kidney Disease			
Bleeding				Kidney Stones			
Bruising Problem				Liver Disease (hepatitis)			
Cancer				Mental Disease			
Colitis				Migraines			
Concussion				Mononucleosis			
Convulsions				Obesity			
Depression				Pneumonia			
Diabetes				Rheumatism			
Drug use				Thyroid Problem			
Eczema				TB			
Emphysema				Ulcers			
Epilepsy				Venereal Disease			
Gall Bladder				Other			

Hospitalizations: List as best you can:

Type of illness/operation	Date	Where

Do you use:

	Yes	Amount		Yes	Amount
Alcohol			Hormones		
Aspirin			Laxatives		
BCP			Med. Herbs		
Coffee			Non-prescription drugs		
Cortisone			Prescription drugs		
Cigarettes			Vitamins		
Electric Blanket			Other		

Other therapies ____________________

Are you allergic to any drugs? ____________________

Are you allergic to foods or other substances? ____________________

What happens when you have an “allergy attack” or “sensitivity reaction”? ____________________

____

Military Service: Where did you serve? ________________________________When________

In what capacity? ____

Family History

Please list ages, if deceased, what died from and at what age

	Living	Died	Cause	Age
Your mother	______	_____	_______________________	_____
Your father	______	_____	_______________________	_____
Your brother(s)	______	_____	_______________________	_____
	______	_____	_______________________	_____
Your sister	______	_____	_______________________	_____
	______	_____	_______________________	_____
Mother's side				
Grandfather	______	_____	_______________________	_____
Grandmother	______	_____	_______________________	_____
Father's side				
Grandfather	______	_____	_______________________	_____
Grandmother	______	_____	_______________________	_____

Do you have children?

	Sex	Age		Sex	Age
____________________	____	____	____________________	____	____
____________________	____	____	____________________	____	____
____________________	____	____	____________________	____	____

Has any blood relative had any of the following?

	Yes No		Yes No
Allergies	__________	Hay Fever	_________
Anemia	__________	Heart Attack	_________
Arthritis	__________	HBP	_________
Asthma	__________	Seizure/Epilepsy	_________
Bleeding (easily)	__________	Sickle cell anemia	_________
Cancer	__________	Stroke	_________
Diabetes	__________	Thyroid trouble	_________
Depression	__________	TB	_________
Eczema/Skin disorder	__________	VD	_________
Genetic disorder	__________	AIDS	_________
Glaucoma	__________	Other ______________________________	
Gout	__________	Other ______________________________	

IV. Symptoms

Please mark 1 (mild), 2 (Moderate), 3 (severe) if any of the following apply to you, now or in the past.

General	Now	Past	
	____	____	Swollen or painful lymph nodes
	____	____	Wounds heal slowly
	____	____	Difficulty stopping bleeding
	____	____	Anemia
	____	____	Bleeding from unusual places
	____	____	Weakness
	____	____	Swollen glands
	____	____	Obvious fatigue
	____	____	Bruise easily
	____	____	Excessive hair growth
	____	____	Unexplained weight loss/gain
	____	____	Prefer hot weather
	____	____	Can’t stand cold
	____	____	can’t stand hot
	____	____	Cold hands or feet
	____	____	Increased thirst
	____	____	Increased hunger
	____	____	excess sweating
	____	____	other (explain) ______________________________
Skin and Nails			
	____	____	Skin rough, dry, scaly, bumpy, itchy
(circle)	____	____	Rashes, warts, moles, cysts (circle which applies)
	____	____	Light or dark patches of skin (circle which)
	____	____	Increased hair growth in unusual places
	____	____	Pimples
	____	____	Color changes in nails
	____	____	Hives
	____	____	Loss of hair
	____	____	Ridges, pits, or spots on nails
	____	____	Infections

	Now	Past		Now	Past	
Head	___	___	Dizziness	___	___	Double vision
	___	___	severe headaches	___	___	Fainting spells
	___	___	Seizures or fits	___	___	Injuries
Eyes	___	___	Corrective Lenses	___	___	Pain, irritation
	___	___	Infections	___	___	Discharge
	___	___	Injuries	___	___	Vision problems
	__________		Last exam			(blurring, double, halos)
Ears	___	___	Discharge	___	___	Infections
	___	___	Pain in ears	___	___	Injuries
	___	___	Hearing trouble	___	___	ringing in ears
	___	___	Itching	___	___	stopped up ears
	___	___	Motion sickness	___	___	other
Nose	___	___	Nose bleeds	___	___	Injury
	___	___	Sinus problems	___	___	Loss of smell
	___	___	Discharge/crusts	___	___	Polyps
	___	___	Sneezing attacks	___	___	Ulcers
	___	___	difficult breathing through nose			
Mouth	___	___	Sores	___	___	Poor dentition
	___	___	Speech difficulties	___	___	Infections
	___	___	Loss of teeth	___	___	Dryness
	___	___	Grinding teeth	___	___	Swelling
	___	___	Sore jaws	___	___	Bad taste
	___	___	Gum problems	___	___	other ______________
Throat						
	___	___	Loss of voice	___	___	Pain
	___	___	Infections	___	___	Swelling
	___	___	Persistent hoarseness	___	___	Constriction
	___	___	Difficulty swallowing			
Neck						
	___	___	Stiffness	___	___	Injuries
	___	___	Swollen glands			

Respiratory

___	___	Unexplained fever	___	___	Night sweats
___	___	Shortness of breath	___	___	Wheezing
___	___	Coughing spells	___	___	Infections
___	___	Expectoration	___	___	Chest pain with breath
___	___	difficult breathing at night (wakes you up)			

Cardiovascular

___	___	Chest pain	___	___	Leg vein trouble
___	___	Shortness of breath	___	___	Murmur
___	___	Irregular beat	___	___	Ankle or foot swelling
___	___	Feel heart pounding	___	___	High Blood Pressure
___	___	Feel heart racing	___	___	Leg pain when walking

How far can you walk or how many stairs can you climb before having to stop? ______________

What makes you stop? ____

Gastrointestinal

___	___	Nausea	___	___	Vomiting
___	___	Blood in stools	___	___	Diarrhea
___	___	Constipation	___	___	Hemorrhoids
___	___	Hard, dry stools	___	___	Vomiting blood
___	___	Anal itching	___	___	Indigestion
___	___	Yellow Jaundice	___	___	Heartburn
___	___	Excess belching	___	___	Parasites
___	___	Trouble swallowing	___	___	Stomach pain
___	___	Foul-odored stools	___	___	Excessive gas
___	___	Infection	___	___	Ulcers
___	___	Loss of appetite	___	___	Injury
___	___	Overweight	___	___	Bloating
___	___	Change in bowel movements			
___	___	Black, pale, green, yellow stools			
___	___	Distress from fats or greasy foods			
___	___	Stools show undigested foods			
___	___	Indigestion occurs 2-3 hours after meals (full, sour, etc.)			

Now	Past	
____	____	heavy, full feeling after eating
____	____	Bad breath; bad taste in mouth; body odor(including feet)
____	____	Stomach pain occurs 5-6 hours after eating; usually at night, relieved by eating, or by drinking milk
____	____	above symptoms aggravated by worry and tension
____	____	History of constipation which alternates with diarrhea
____	____	Indigestion occurs immediately after eating
____	____	Have difficulty belching, with stomach cramps and colicky sensations in stomach
____	____	Nervousness, shaky feeling, headaches; relieved by eating sweets
____	____	Irritable if late for meal, miss meal, or before eating
____	____	Sudden, strong craving for sweets or alcohol
____	____	Wake up at night feeling hungry
____	____	Gain weight, fail to lose on diet
____	____	Feel better mornings, worse afternoons
____	____	Good appetite, but fail to gain or lose weight
____	____	Sleepy during day. Time? ______________________

How often do you have bowel movements? ____

Have you had a change of appetite? Increased or decreased ____________________________

What does your diet consist of? ____

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How frequently do you eat? ____

Who prepares your food? ____

Do you snack? On what? ____

What food(s), condiments(s), or any other substances (ie. Tobacco, alcohol, coffee, etc.) Do you crave? ____

Are you repelled by, or do you dislike any foods? Please identify: _________________________

Are there any foods that trouble you or aggravate you? Do not agree with you? Explain:

____

____

Urinary

Now	Past		Now	Past	
____	____	frequent urination	____	____	Night urination
____	____	Painful urination	____	____	Foul odor of urine
____	____	Trouble holding urine	____	____	Trouble starting urine
____	____	Urine bloody, cloudy, dark, foamy (which?)			

Male Genital

____	____	Discharge from penis	____	____	Painful erection
____	____	Infertility	____	____	Infection
____	____	Prostate problems	____	____	Injury
____	____	Difficulty achieving or maintaining an erection			
____	____	Lumps, swelling, or pain in testicles			

Do you want birth control information? ____

What kind of contraception do you use? ____

Female Genital

____ ____ Discharge from vagina

____ ____ Painful intercourse

____ ____ Pelvic pain

____ ____ Flushes of heat

____ ____ Infertility

____ ____ Difficulty feeling sexually aroused

____ ____ No lubrication when aroused

____ ____ Never or seldom have orgasms

____ ____ Menstrual flow is excessive

____ ____ Menstrual flow is absent

____ ____ Bleeding or spotting between periods

____ ____ Pain before, during, or after periods (circle)

____ ____ Breasts: lumps, swelling, soreness (circle)

____ ____ Infection. Location: ______________________ When:_________

____ ____ Premenstrual symptoms: cramping, water retention, breast tenderness, headaches, depression, irritability, others:

Explain: ____

Do you want birth control information? ____

Period every _____days. Regular? Yes No

Period usually lasts ____ days (average)

Number of tampons or pads used per day ______

Date of last period _________________________

Number of pregnancies ______________________

Number of births ___________________________

Number of nursed children __________________If trouble with lactation?__________

Number of miscarriages ______________________

Number of abortions ________________________

Female Genital - continued

Date of last PAP ____________________________
How old were you when you started having menstrual periods? ______________________
Have you ever used hormones or birth control pills? ________When? _________________
What form of contraception do you use? ____
Any complication(s) of pregnancy? _________ If yes, please list:______________________
____
List any pelvic surgery: ____
____

Musculoskeletal

Now	Past	
____	____	Whiplash injury? When? ____________________________________
____	____	Back pain
____	____	Spinal curvature or scoliosis
____	____	Muscle cramps. Where? ______________________________
____	____	Joint pain or stiffness. Where? ___________________________
____	____	Swelling. Where? __________________________________
____	____	Injury. Where? ____________________________________
____	____	Other. Describe ___________________________________

Have you ever had arthritis? _______When?___________________Where? _________________
What kind? ____

Neurological

Now	Past	
____	____	Loss of balance
____	____	Paralysis
____	____	Faintness
____	____	Lack of strength
____	____	Involuntary movement
____	____	Speech slurred
____	____	Loss of consciousness
____	____	Numbness. Where? ___________________________________
____	____	Convulsions (seizures, stiffness)
____	____	Tremor (shaking, trembling)

Mental

Now	Past		Now	Past	
____	____	Restlessness	____	____	Nervousness
____	____	Excessive worry	____	____	Trouble sleeping
____	____	Memory trouble	____	____	Crying spells
____	____	Trouble concentrating	____	____	Depression
____	____	Nightmares	____	____	Easily angered
____	____	Excess stress in life	____	____	Fearful
____	____	See things others don't	____	____	Mood swings

Now	Past	
____	____	Feel like killing self
____	____	Feelings of worthlessness
____	____	Feel better from exercise
____	____	Trouble getting along with others
____	____	Think others want to hurt me
____	____	Difficulty expressing feelings
____	____	Loss of someone dear through death or separation
____	____	Don't know how to relieve stress
____	____	Peculiar sensations
____	____	Are you generally late for appointments or do you leave things undone until the last minute?

Explain: ____

____

Additional

Is there anything else you wish to add? ____

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HEALTH HISTORY

Name ____ Birth Date__________
Occupation ____ Birth Time _________
Age_______ Sex ____________ Birth Place _________

As well as you can, please list both the acute and chronic ailments your have experienced, how you treated them and the result. Thank you.

Age	Ailment	Treatment	Result

Dental history
Do you have any specific dental problems? Describe_______________________________________
Do you have dental examinations on a routine basis? Last visit____________________________
Do you think you have active decay or gum disease?______________________________________
Do you brush and floss(hydrofloss) on a routine basis? Describe____________________________
Do your gums ever bleed?____
Do you have any root canals? Metal fillings? How many? ___________________________________
Do you ever have clicking, popping or discomfort in the jaw joint? __________________________
Do you brux or grind? ____
Do you smoke or chew? Any sores in your mouth? Discuss_______________________________

Environment
Do you live close to a high-voltage line?
Do you have a heating system with electrical convection heaters or electrical radiation?
Do you sleep next to a bedside table lamp?
Do you live in a wooden house?
Have you had the electrical and magnetic fields in your home measured?
Do you leave your mobile phone at night in standby mode next to your bed?
How many feet away?
Is you house equipped with electronic microwave alarm system?
Do you use a cordless telephone in your home?
Do you have an electrical alarm clock connected to a power supply next to your bed?
Do you feel unwell in certain rooms of your home?
Are you able to sleep thru the night?
Which way does your bed face?
Do you use a mobile phone, headphone, Bluetooth?
Do you work near a transmission antenna for mobile telephones?
Do you work with a computer with a cathode ray screen?
Is your computer equipped with remote accessories?
Is your house equipped with an infrared alarm system?
Do you use a microwave?
Do you sleep with an electric blanket or heating pad?
Do you have light dimmers?   Use florescent lights?
Sit in front of a video screen?