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## HEALTH QUESTIONNAIRE

### Personal Information

Full name \_\_\_\_\_ Name you wish to be called \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: H) \_\_\_\_\_ W) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Date of birth \_\_\_/\_\_\_/\_\_\_ Gender: M / F

Insurance Company: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Who were you referred by? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone: \_\_\_\_\_

### Primary Concern

What brings you to my office?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of original condition: \_\_\_\_\_ Date of most recent occurrence: \_\_\_\_\_

Was there an event that created the condition? \_\_\_\_\_

\_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_\_\_

What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

Is the condition getting worse? \_\_\_\_\_ Constant? \_\_\_\_\_

Worse at a certain time of day? \_\_\_\_\_

Is this condition interfering with: Work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Activity? \_\_\_\_\_ Other? \_\_\_\_\_

Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Health History

List other current health issues & problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List other practitioners seen, treatments, self-care activities, and results: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List illness you have had not previously mentioned, if any: \_\_\_\_\_

\_\_\_\_\_

List all surgeries you have had, with dates and results: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been in an accident or seriously injured? (if so, please describe): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any dental or TMJ problems? **Y N** (if so, please describe)

\_\_\_\_\_

Have you had your wisdom teeth or other teeth removed? **Y N** \*Have you ever had a root canal? **Y N**

(if yes note which teeth) \_\_\_\_\_

List all medications, vitamins, herbs and other supplements you are now taking, the dose, and reason for taking (please bring actual bottles w/pills in with you to your appointment): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all medications and other substances (i.e.: foods) to which you are allergic:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father \_\_\_\_\_ Mother \_\_\_\_\_ Children \_\_\_\_\_

Grandparents \_\_\_\_\_ Brothers \_\_\_\_\_ Sisters \_\_\_\_\_

### General

\*Describe your use of: Cigarettes/Tobacco \_\_\_\_\_ Alcohol \_\_\_\_\_ Other drugs \_\_\_\_\_

\*Describe your present exercise habits including frequency per week, duration, and heart rate: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\*How many hours per night do you sleep? \_\_\_\_\_ \*Do you fall right asleep? **Y N** \*Do you wake up feeling refreshed? **Y N**

\*Do you sleep through the night without awaking? **Y N** \*Do you remember your dreams? **Y N**

\*Do you snore? **Y N** \*Do you have night sweats? **Y N** \*Do you have nightmares? **Y N**

\*Do you grind your teeth at night (bruxism)? **Y N** \*Do you have restless legs (RLS)? **Y N**

\*When did you last receive the following (leave blank if it does not apply to you), (please remember to bring copies).

\*Cholesterol or other blood tests \_\_\_\_\_

\* Prostate Exam \_\_\_\_\_ \*Other \_\_\_\_\_

## Pain Questionnaire

(Skip to the next section if you are not currently experiencing pain.)

Please place a single vertical line through the scale below at the point that best describes your pain.  
(0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

A = Ache

B=Burning

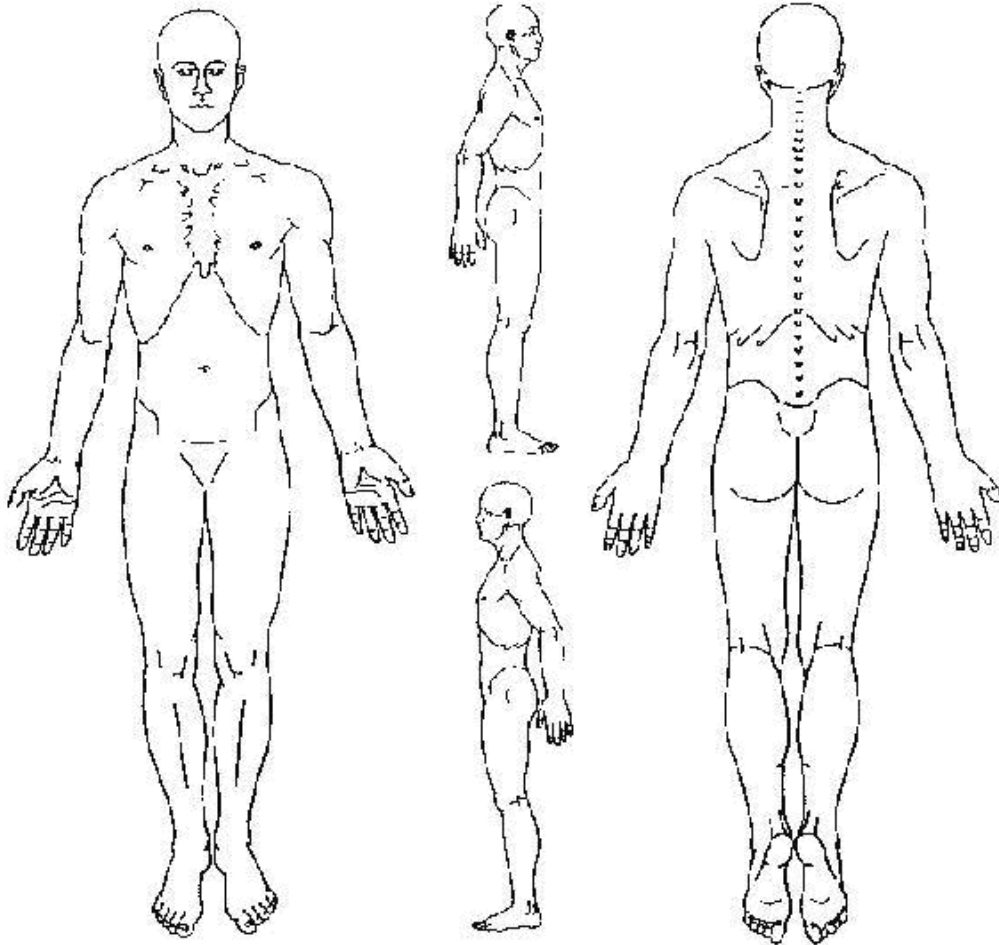
N=Numbness

O=Other

P=Pins & Needles

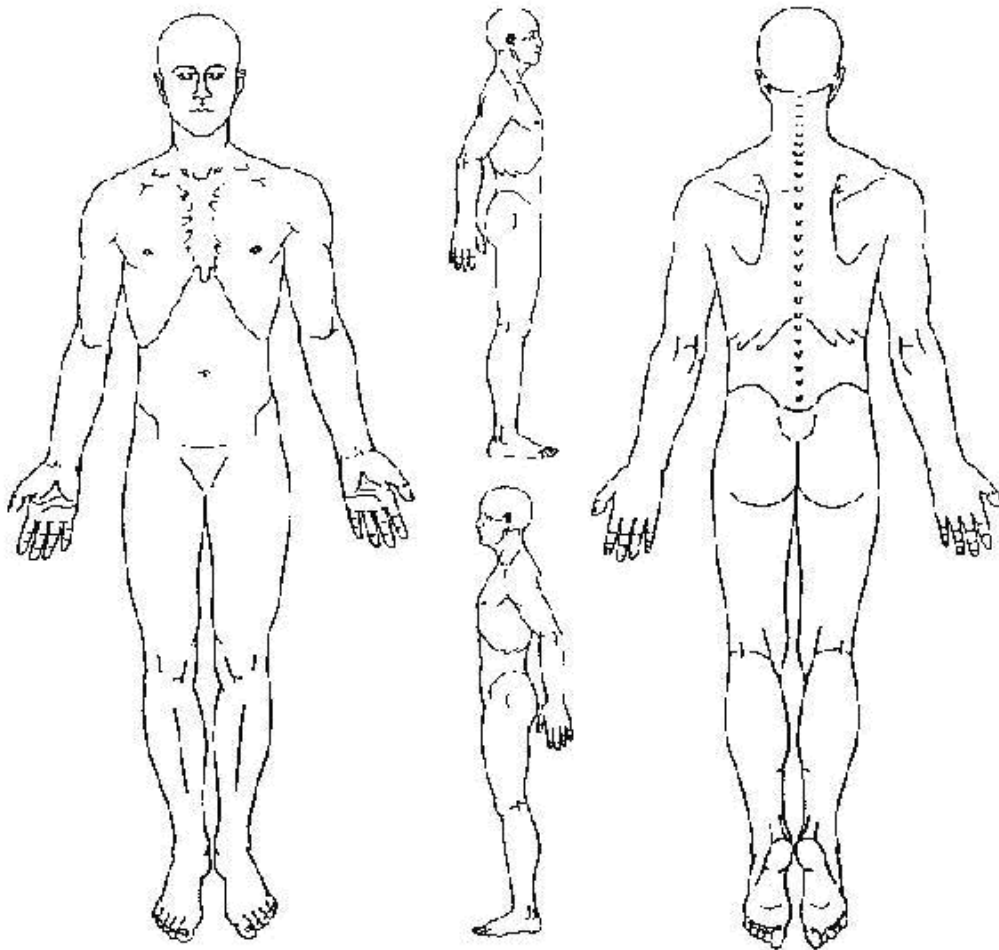
S=Stabbing

T=Throbbing



## History of Injury

Please mark with an "X" all the places on your body which have ever been injured (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.



## SYMPTOM SURVEY

Circle the symptom if you are currently experiencing it or it is a common occurrence. Underline the symptom if it is now not a problem, but was sometime in the past, (over 3 months ago).

### GENERAL

- Low energy-fatigue
- Weakness
- Fever-Chills
- Headaches
- Lack of Sleep
- Reduced Mental Acuity

### SKIN

- Dry skin
- Itching
- Varicose veins
- Cold or canker sores/fever blisters
- Boils
- Hives
- Rashes
- Sores
- Change in your skin/nails

### EYES

- Cataracts/Glaucoma
- Eye pain
- Double vision
- Far or near sightedness
- Flashing lights
- Spots, specks, or floaters

### EARS

- Ear Discharge/Excessive Wax
- Earaches or Infections
- Hearing Loss
- Ringing/Tinnitus
- Vertigo/dizziness

### NOSE/SINUS

- Sinus congestion
- Frequent colds/infections
- Nosebleeds

### NECK

- Goiter
- Lumps
- Pain/Stiffness
- Swollen Glands

### RESPIRATORY

- Asthma
- Bronchitis
- Cough
- Pneumonia
- Tend to Hold Breath
- Wheezing
- Sputum
- Trouble Breathing w/Exercise

### CARDIAC/VASCULAR

- Arrhythmia
- Chest Pain
- Heart Trouble
- Murmur
- High Blood Pressure
- Palpitations
- Shortness of Breath
- Swollen Feet or Lower Legs
- Racing or Pounding Heart
- Blood Clots
- Leg Cramps
- Poor Circulation

MOUTH/THROAT

- \_ Dentures
- \_ Tooth decay
- \_ Frequent sore throats
- \_ Grind teeth at night
- \_ Hoarse voice/frequent loss of voice

NEUROLOGIC

- \_ Blackouts
- \_ Fainting
- \_ Numbness
- \_ Paralysis
- \_ Dizziness
- \_ Tremors
- \_ Seizures

GASTROINTESTINAL

- \_ Belching
- \_ Flatulence/Gas
- \_ Black or Tarry Stools
- \_ Blood in Stool
- \_ Change in Stool
- \_ Colitis
- \_ Constipation
- \_ Diarrhea
- \_ Distention
- \_ Excessive Hunger
- \_ Heartburn
- \_ Food Intolerance
- \_ Hemorrhoids
- \_ Indigestion
- \_ Nausea
- \_ Poor Appetite
- \_ Stomach Pain
- \_ Trouble Swallowing
- \_ Vomiting

PSYCHOLOGICAL

- \_ Anxiety
- \_ Depression
- \_ Insomnia/Hard to Fall Asleep
- \_ Nervousness
- \_ Poor Memory/Forget Quickly
- \_ Violent Thoughts
- \_ Suicidal Ideas
- \_ Tend to Worry

ENDOCRINE

- \_ Diabetes
- \_ Excessive Thirst or Hunger
- \_ Excessive Sweating
- \_ Lack of Sweating
- \_ Heat or Cold Intolerance
- \_ Thyroid Problem
- \_ Hair Loss
- \_ Dizzy when Rising Quickly
- \_ Excessive Weight Loss
- \_ Excessive Weight Gain

HEMATOLOGIC

- \_ Anemia
- \_ Bruise easily

URINARY

- \_ Frequent urination
- \_ Blood in urine
- \_ Incontinence
- \_ Painful urination
- \_ Urinate more than once at night

MUSCLES & JOINTS

- Arthritis
- Tendonitis
- Bursitis
- Gout
- Trouble with/poor posture
- Chronic pain
- Pain with specific movement(s)
- Pain relieved with anti-inflammatory drugs  
(aspirin, ibuprofen,  Itching/rashes Vioxx, etc...)
- Pain, tenderness, or numbness in:
  - Neck
  - Shoulders
  - Arms
  - Elbows
  - Wrist/hands
  - Upper back
  - Lower back
  - Hips
  - Knees
  - Feet/ankles

\*\*MALES ONLY: SEXUAL/HORMONAL

- Prostate problems
- Hernia
- Erection trouble
- Discharge
- Premature ejaculation
- Sexually transmitted disease
- Testicular lump/pain
- Vasectomy

\*\*FEMALES ONLY:

- Bleeding between Periods
  - Decreased Sexual Interest
  - Pain with Intercourse
  - Discharge
  - Itching
  - Sores
  - Yeast Infections
  - Sexually Transmitted Disease
  - PMS
    - Breast Tenderness
    - Cramping/Bloating
    - Back Pain
    - Over-Emotional
    - Tired/Fatigue
    - Other Pain
    - Other Symptoms
  - Age at First Period\_\_\_\_\_
  - Number of Days in Cycle\_\_\_\_\_
  - Usual Length of Period\_\_\_\_\_
- Start of Last Period Date\_\_\_\_\_
  - Number of Pregnancies\_\_\_\_\_
  - Number of Deliveries\_\_\_\_\_
  - Complications with Pregnancies \_\_\_\_\_
  - Birth Control Method\_\_\_\_\_



## DIET HISTORY

How much do you drink each day (8oz): Water: \_\_\_\_\_ Juice: \_\_\_\_\_ Soda Diet: \_\_\_\_\_ Soda Regular: \_\_\_\_\_

Coffee: Regular: \_\_\_\_\_ Decaf: \_\_\_\_\_ Tea: Regular: \_\_\_\_\_ Tea Sweet : \_\_\_\_\_ Energy Drinks/Other: \_\_\_\_\_

List oils or fats that you use in cooking: \_\_\_\_\_

Do you frequently skip meals? **Y N** Are you on any special diet or nutrition program? **Y N**

Describe:

\_\_\_\_\_

Are you allergic or sensitive to any foods? **Y N** If yes, name the foods and describe the problem.

\_\_\_\_\_

What foods do you dislike? \_\_\_\_\_ What is/are your favorite food(s)? \_\_\_\_\_

Circle the foods you crave:

Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods Spicy foods Sour foods Cereals Dairy  
Other individual \_\_\_\_\_

\*Do you use: (circle) butter margarine shortening coconut oil \*Do you eat organic foods? **Y N**

\*Do you know what partially hydrogenated fats are? **Y N** \_\_\_\_\_ If yes, do you eat them? **Y N**

\*Do you eat from fast food restaurants? **Y N** -- If yes, how often? \_\_\_\_\_

What do you usually eat for breakfast? \_\_\_\_\_

What do you usually eat for lunch? \_\_\_\_\_

What do you usually eat for dinner? \_\_\_\_\_

What do you usually eat for snacks (in between meals and/or before bed)? \_\_\_\_\_

What foods do you eat a lot of (at least once a day, every day)? \_\_\_\_\_

How many bowel movements do you have per day? \_\_\_\_\_

### **A Bit More ----**

\*Type of sport/activity/exercise routine you participate in:

\*Hours you train/exercise average per week: \_\_\_\_\_ \*Do you train by yourself or with others? (circle)

\*Do you use a heart rate monitor? **Y N** \*What type of shoes do you wear? (Name/Style) \_\_\_\_\_

## **Office Policies**

### **Financial**

Dr. Pietrantone does not participate (not in-network) with any insurance. We will provide you with a receipt with the appropriate diagnosis codes and procedure codes. We are unable to fill out any paperwork for approvals, authorizations, etc. This would become too overwhelming if we had to do this for all patients. Patients may opt to submit this to their insurance on their own. However any reimbursement depends solely on your insurance plan's coverage and limits.

All payments for appointments are due at the time of the visit.

All supplements and additional supplies are the patient's responsibility and payment is due at the time of the visit.

Because we value the time spent with our patients, appointments that you make are reserved solely for you and the doctor. Please give our office at least 24 hours advance notice for any cancellation. If 24 hours notice is not given 50% of the appointment fee will be billed you. You will not be able to schedule subsequent appointments if you have an outstanding no-show balance.

We accept all major credit cards, FSA cards, HSA cards, cash and checks.

### **Emergencies**

If you have a medical emergency and are unable to contact us through the office phone, 716-655-1421, please go to the Emergency Room or dial 911.

### **Confidentiality**

We will never sell your information such as emails or phone numbers. Any requests for documentation by doctors, family, and insurance companies will require your written consent.

By signing below you understand and agree to the above office policies including the 24-hour cancelation fee. Bring this form to your first appointment. We cannot begin treatment without it.

Name(printed)\_\_\_\_\_

Name(signed)\_\_\_\_\_

Date\_\_\_\_\_