FOR THE OFFICE OF MARSHA NUNLEY, MD

H.E.A.L. MEDICAL CORP.

Date_______________

Name____ Email__________________________________

Address______________________________________ Phone (H)______________________________

City/State/Zip__________________________________ Phone (W)______________________________

Sex________ Age______ DOB_____/_____/______ Phone (C) ______________________________

Emergency Contact Info:

Name: _________________________ Relation____________________ Phone_______________________

Your current medical team

Primary Physician: _______________________________ Phone Number: __________________________

Preferred Pharmacy______________________________ Phone Number: __________________________

Health History

What brings you to see Dr. Nunley? ____

____

What are your health goals?

____

____

Please list previous medical illnesses including surgery and hospitalizations:

1. ________________________ Date ________________ Place ________________
2. ________________________ Date ________________ Place ________________
3. ________________________ Date ________________ Place ________________
4. ________________________ Date ________________ Place ________________
5. ________________________ Date ________________ Place ________________

Do you have an ALLERGY to a drug or other substance? Y / N (please list below)

____

Current Medicine Used:

Drug Name	Strength	How Often Taken

Have you ever had diagnostic studies? None_____ Only those listed below_______

Upper G.I. (Stomach X-Ray) Year______ Result______________________

Colonoscopy Year______ Result______________________

Gall Bladder

Barium Enema (Colon X-Ray) Year______ Result______________________

Electrocardiogram Year______ Result______________________

Injuries Year______ Result______________________

Others______________________ List___________________________________

Immunizations

Measles Mumps Rubella Polio Date______ Tetanus & Diphtheria Date__________

Chicken Pox Date______ Pneumovax Date______ Tetanus Booster Date__________

DPT Date______ Influenza Date______ Hepatitis A Series #1____ #2____

Hepatitis B Series #1_____ #2_____ #3_____

Do you have dental amalgams (silver fillings) or root canals? Yes______ No______

Family History: Please tell us about your family. Also, please include any family member with a history of, tuberculosis, diabetes, cancer, emphysema, kidney disease, ulcer, stroke, nervous breakdown, and gallbladder disease.

	Age	Health Problem	Age at Death	Cause
Father	________	______________________	___________	__________________
Paternal Grandfather	________	______________________	___________	__________________
Paternal Grandmother	________	______________________	___________	__________________
Mother	________	______________________	___________	__________________
Maternal Grandfather	________	______________________	___________	__________________
Maternal Grandmother	________	______________________	___________	__________________
Brothers (how many in all?__)	________	______________________	___________	__________________
Sisters (how many in all? ___)	________	______________________	___________	__________________
Sons (how many in all? ____)	________	______________________	___________	__________________
Daughters (how many in all? ____)	________	______________________	___________	__________________

Any other Family members with illnesses noted above?____

How well have things been going for you? (Very well, Fair, Poorly, Very Poorly, Doesn't apply)

At School________________	With close friends___________	With your children__________________
In your Job_______________	With sex__________________	With your parents___________________
In your social life___________	With your attitude__________	With your spouse/partner_____________

Social and Socioeconomic History

Occupation ______________________ Employer _________________________

Years of education/highest degree _______________________________________

Present marital status Single Partner Married Divorced Widowed

Spouse or partner's name: ____

Number of children? _______ Ages? _____________

Number of people in your household, including your children _________________

Tobacco, Alcohol, Recreational Drug Use

Do you use tobacco in any way? Y / N If yes, frequency? ___________________

If yes, are you interested in quitting? Y / N

Have you smoked in the past? Y / N If yes, when did you stop? _____________

Do you drink alcoholic beverages? Y / N If yes, frequency? (drinks per week)

Do you use recreational drugs? Y / N If yes, type ________________________

If yes, are you interested in quitting? Y / N

Sexual activity

Sexually active Y / N

Birth control method? ____

Do you practice safe sex? Y / N

Energy level

Describe your energy level throughout a typical day rating on a scale of 1-10, 1 being extreme fatigue and 10 feeling great and energized

Early morning **Mid morning to Noon** **Mid afternoon** **Evening**

Describe any associated food or drink cravings (sugar, coffee, cola's etc)

____

____

____

List the over the counter medicines, vitamins, herbs, and food supplements you take. ___None

____

____

____

____

____

____

____

Have you seen an integrative provider in the past 12 months? Y / N **Ever?** Y / N

Please circle those practices, which you have tried

Acupuncture	Chiropractic Care	Light Therapy	Neuro-Linguistic Programming
Bodywork	Homeopathy	Meditation	Traditional Chinese Medicine
Chelation Therapy	Hypnosis	Naturopathy	Yoga

Other____

____

____

Nutrition Evaluation
Please list all foods and drinks you have consumed in the past 24 hours.
Include meals, snacks, beverages and condiments

Food Item	How Prepared (baked, fried, etc.)	Amount (cup, tbs., oz., etc)

Is this a typical day? If not, why? Please describe: ____

____

How many servings of fruit do you eat/drink each day? (serving = 1 small piece of fruit, ½ cup juice, ½ cup canned or chopped fruit, ¼ cup dried fruit)____

____

How many servings of vegetables do you consume each day? (serving = ½ cup raw or cooked vegetables, 1 cup fresh, green leafy vegetables, ¼ cup dried vegetables, or 1 small piece)

____

Are you currently on a special diet? If so, please describe:____

____

Do you eat meat? If so, what kind and how much? ____

What type of oil or spreads do you add to your food?____

What do you drink on a typical day?

____

How would you describe your relationship with food?____

Is there anything special about your diet that we should know? If so, please explain:_________________

____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.?

Yes ____ No ____

If yes, are these symptoms associated with any particular food or supplement(s)? Yes_____ No_____

Please name the food or supplement and symptoms(s). Example: Milk = gas & diarrhea

____

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc? Yes_____ No_____

Does skipping a meal greatly affect your symptoms? Yes_____ No_____

Have you ever had a food that you craved or really “binged” on over a period of time? (food craving may be an indicator that you may be allergic to that food) Yes_____ No_____

If yes, what food(s)? ____

Do you have an aversion to certain foods? Yes_____ No_____

If yes, what foods? ____

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Review of Systems

Please check any current symptoms you may have:

Constitutional

___ recent fever or sweats

___ unexplained

___ weight loss/gain

___ unexplained weakness/fatigue

___decline in libido

Respiratory

___ cough/wheeze

___ coughing up blood

Skin

____ Rash

____ New or change in mole

___ Thin, ridged, or splitting, crumbling nails

Eyes

____ Changes in vision

Gastrointestinal

____ Heartburn/reflux

____ Blood or change in bowel movement

____ Nausea/vomiting/diarrhea

____ Pain in abdomen

____ Irritable bowel syndrome/digestion problems

Neurological

____ Headaches

____ Memory loss

____ Fainting

Ears/Nose/Throat/Mouth

____ Difficulty hearing

____ Hay fever/allergies

____ Trouble swallowing

Cardiovascular

____ Chest pains/discomfort

____ Palpitations

____ Short of breathe with exertion

Genitourinary

____ Painful/bloody urination

____ Leaking urine

____ Nighttime urination

____ Unusual vaginal bleeding

____ Concern with sexual function

Psychiatric

____ Anxiety/stress

____ Sleep problem

____ Depression

Blood/Lymphatic

____ Unexplained lumps

____ Easy bruising/bleeding

Breast

____ Breast lump

____ Nipple discharge

Musculoskeletal

____ Muscle/joint pain

____ Recent back pain

Endocrine

___ Cold/heat intolerance

___ Increased thirst/appetite

Patient Name____________________________________ DOB_____________________

Medical Symptom Questionnaire (MSQ)

Rate each of the following symptoms based on your typical health profile for the last 6 months

Point System: 0-4

0 = Never or almost never have the symptom

1 = Occasionally have it, effect is not severe

2 = Occasionally have it, effect is severe

3 = Frequently have it, effect is not severe

4 = Frequently have it, effect is severe

Head
TOTAL___

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Eyes
TOTAL ___

___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision *(doesn't include near- or far- sightedness)*

Ears
TOTAL ___

___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Nose
TOTAL ___

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing Attacks
___ Excessive mucus formation

Mouth/ Throat
TOTAL ___

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen or discolored tongue, gums or lips

Skin
TOTAL ___

___ Acne
___ Hives, rashes, dry skin
___ Hair loss
___ Flushing, hot flashes
___ Excessive sweating

Digestive
TOTAL___

___ Nausea, vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching, passing gas
___ Heartburn
___ Intestinal/stomach pain

Joints/ Muscle
TOTAL ___

___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness

Weight
TOTAL ___

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive Eating
___ Water retention
___ Underweight

Energy/ Activity
TOTAL ___

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

Mind
TOTAL ___

___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

Emotions
TOTAL ___

___ Mood swings
___ Anxiety, fear, nervousness
___ Anger, irritability, aggressiveness
___ Depression

Other
TOTAL ___

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

Grand Total ______________________________

Patient Name___________________________________ DOB_____________________