COSTA
LIFESTYLE MEDICINE

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Biochemistry Comprehensive Intake Form

PLEASE KEEP A COPY FOR YOUR RECORDS

Confidential Patient Health Record

Please complete the following questionnaire as thoroughly as possible to aid us in your diagnosis and treatment. This will become a part of your confidential medical record and will not be released unless you have authorized us to do so.

Name: _____ Date: _____

Address: _____ Unit: _____

City: _____ State: _____ Zip Code:_____

DOB: _____ Age: _____ Sex: **M F Other**:_____

Email: _____

Phone: **Home:** _____**Cell:** _____ **Work:** _____

Referred By/How did you hear about us?_____

Emergency Contact Name and Phone: _____

Circle One: **Single / Married / Divorced** Partner's Name/Occupation: _____

Doctor's Name: _____ Doctor's Phone Number:_____

Specialist's Name: _____ Specialist's Phone Number:_____

Overall Health (circle one**): Excellent/ Good / Fair / Poor Other:** _____

Occupation: _____

Occupational Stresses (chemical, physical, psychological, etc.) _____

_____

Hobbies/Past-time:_____

Place of Birth:_____

Denomination/Religious/Spiritual Beliefs (OPTIONAL):_____

What level of change to your lifestyle/habits are you willing to make to improve your health? (circle one):

Whatever it takes **Significant change** **Some change** **No change**

☙ Chief Complaint Intake Form ❧

☙ What are your chief complaints?

☙ When did the symptoms begin?

☙ What precipitated or started the condition?

☙ Does anything make it better or worse?

☙ Can you think of any other complaints or problems, even if you think they may be insignificant or unrelated to your main complaint?

☙ Please describe your long and short term goals here:

Patient Name:_____Date:_____

☙ Medical Health History Form ❧

Please check the appropriate box that correlates with the statement
Y = Yes (currently), N = No, P = Past

General:	Y	N	P
Do you have any tattoos?			
Have you ever served in the armed forces?			
Have you ever had a blood transfusion? if so, approximate date of transfusion:_____			
Have you ever been exposed to chemicals, pesticides, etc? Specify:_____			
History of concussion or of hitting your head?			

Cardiovascular: (Circle all that apply)

Shortness of Breath High Blood Pressure Low Blood PressureFainting

Phlebitis Hand/Feet Swelling Blood Clots(DVT, PE, Stroke)

Dizziness Irregular Heartbeat

Pain or abnormal sensation in chest (Palpitations, tightness, etc.)

Personal history of heart attack stents, cardiac surgery?_____
Other:_____

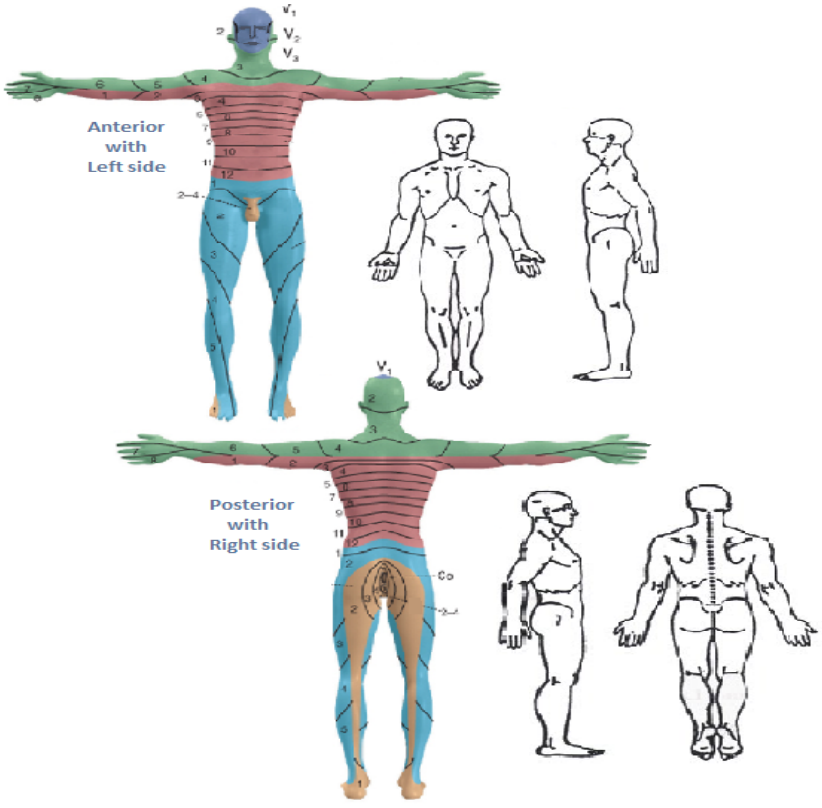
Respiratory: (Circle all that apply)

Persistent Coughing Shortness of Breath Asthma COPD

Bronchitis Coughing Blood Pneumonia Production of Phlegm
Difficulty breathing while lying down

Other:_____

Musculoskeletal/Pain:	Y	N	P
Joint Pain?			
Aches or pain in the neck, middle back, or low back?			
Muscle Pain?			
Pain, numbness, or tingling in the arms of legs?			
Joint/ Muscle pain in the night?			
Hypermobile Joints? (fingers, elbows, knees, shoulders)			
Tendon/ligament injuries?			
Jaw pain/clicking jaw/grind teeth?			
History of injury or car accidents? Briefly what happened? _____ _____			
Other:_____			



Please mark/circle where you have pain symptoms.

Describe the pain in a word or two (stabbing, dull, throbbing, constant, migrating) AND list pain level (10= worst, 1 =barely feel):

Severity: 0 1 2 3 4 5 6 7 8 9 10

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name:_____Date:_____

Gastrointestinal: (Circle all that apply, then answer 1-4)

Heartburn/Reflux **Nausea/Vomiting** **Diarrhea/Loose Stools** **Fecal Incontinence**

Rectal Pain **Hemorrhoids** **Bad Breath** **Constipation**

Distress in upper abdomen or stomach **Problems with gas or belching**

1. How many times per day/week do you have a bowel movement?_____
2. How often are you constipated?_____
3. Bloody stools?_____**Red blood?**_____ **Black or tarry looking?**_____
4. Other:_____

Genito-Urinary: (Circle all that apply)

Pain with Urination **Frequent Urination** **Urgent Urination**

History of Kidney Stones **Genital Odor/ Discharge.** **Genital Sores/Pain**

Sexual Function Issues **Blood in Urine**

Loss of Bladder Function/Urinary Incontinence

History of Sexually Transmitted disease(eg. HPV, Gonorrhea,Herpes)

Recurrent Urinary Tract Infections: How frequent?_____

Other:_____
MALES ONLY:
Prostate Problems **Burning/ Pain with Ejaculation**

Gynecology and Pregnancy: (Circle all that apply, then answer 1-6)

Premenstrual Symptoms **Irregular Periods** **Body Changes**

Miscarriages **Gynecology Surgeries** **Breast Lumps**

1. Age of first Menses?_____
2. Flow? Describe_____
3. Length of period?_____
4. Last Menses?_____
5. Number of Pregnancies?_____**Live births**_____**Premature births**_____
6. Birth Control? Type:_____
7. Menopause Age:_____
8. Do you take Female Hormones?_____

Head, Eyes, Ears, Nose and Throat: (Circle all that apply)

Headaches	**Migraines**	**Dizziness**	**Poor Hearing**	**Sinus Problems**
Near/Far Sighted	**Blurry Vision**	**Night Blindness**	**Color Blindness**	**Ear Pain**
Spots on eyes	**Pterygium**	**Cataracts**	**Glaucoma**	**Ear Wax**
Tinnitus	**Ear Discharge**	**Nose Bleeds**	**Mouth/Tongue Sores**	
Chronic Sore Throat		**Auras, Sounds, Smells**		

Other:_____

Dental: (Circle all that apply)

Teeth Problems	**Cavities**	**Fillings**	**Braces**
Crowns gold/ Porcelain	**Tooth Pain**	**Extractions**	**Facial Pain**
Grinding Teeth	**Root Canals**	**History of Tooth Abscess**	
Jaw Pain	**Amalgams**	**Swollen/Bleeding Gums**	

Surgeries? Describe: _____
Other:_____

Neurological: (Circle all that apply)

Seizures	**Vertigo**	**Nausea/Vomiting**
Loss of Consciousness	**Weakness in limb/body**	**Stumbling/Tripping**
Loss of Coordination	**Balance Problems**	**Loss of Grip Strength**
Loss of Fine Motor Skills	**Numbness/ Tingling**	

History of Concussion? Describe:_____

Other:_____

Diagram of Tooth Numbering

Adult Dentition: Permanent Teeth **1 - 32**

Child Dentition: Primary Teeth **A -T**

Please mark teeth that have current dental issues or teeth that have had previous dental interventions.

Use the key below to mark specific issues and give a brief explanation:

KEY:

R = Root canal **CR** = Crown

P = Pulled **B** = Bridge

I = Implant **CA** = Cavities

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

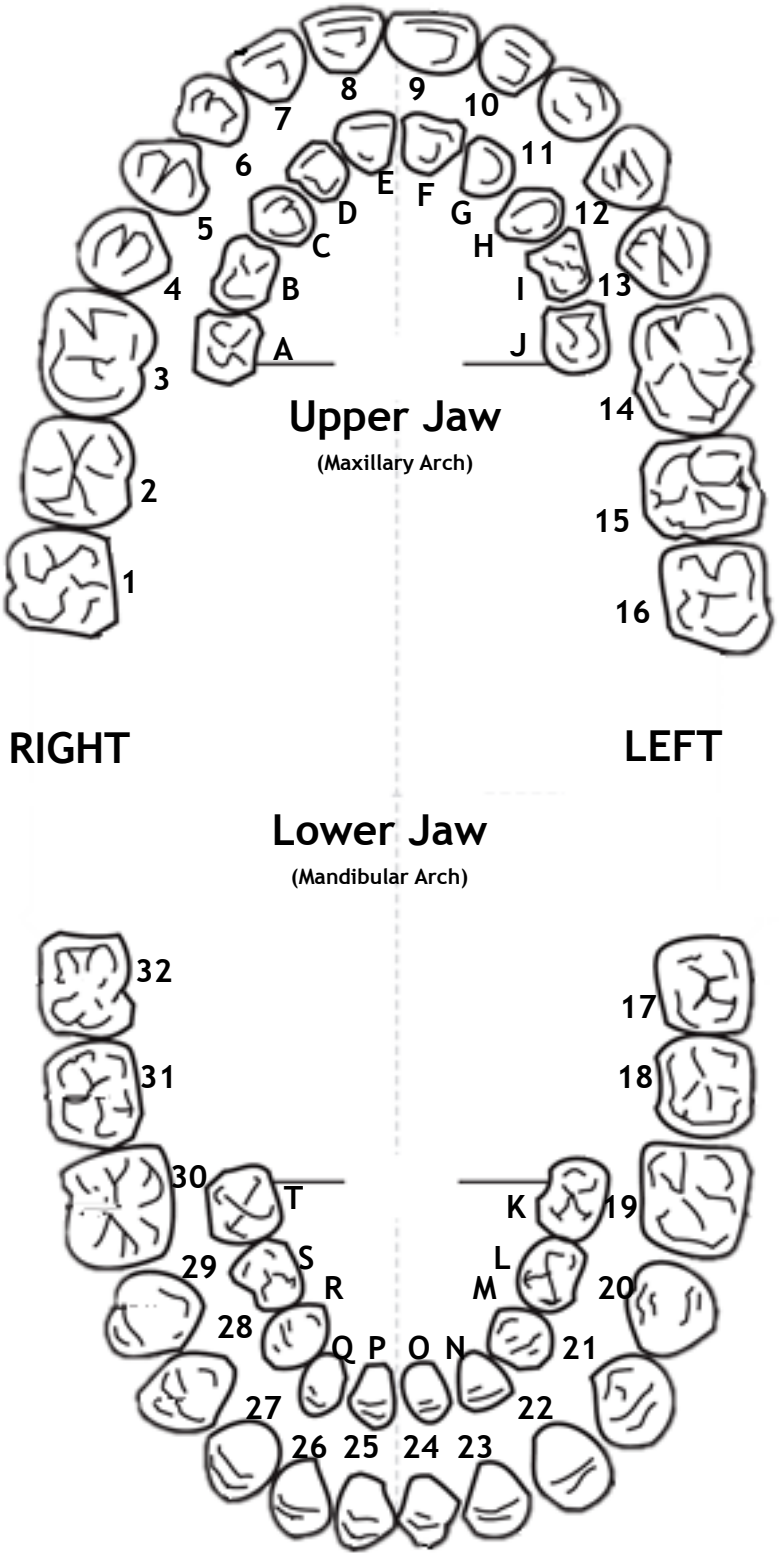
Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____

Tooth #_____



Patient Name:_____Date:_____

Neuropsychological: (Circle all that apply then answer 1-3)

Depression **Anxiety** **Poor Memory** **Foggy Thinking**

Anger Issues **Suicidal Ideation** **Suicide Attempts**

1. Do you cry? _____Do you prefer to be alone?_____ or do you prefer comfort?_____
2. Treated for other emotional issues? _____
3. Have you ever been hospitalized for psychological issues?_____

Stress Screening:	Y	N	P
Trouble dealing with Stress?			
Does stress lead to digestive problems?			
Can you relax when you want?			
Does stress affect your sleep?			
Do you bite your nails?			
Do you abuse food/alcohol/ tobacco to deal with unpleasant feelings?			
Do you feel your health is out of your hands?			
Do you avoid conflicts at your expense?			
Other:_____			

Living Environment:

1. What type of building do you live in? House__Apartment___Mobile home___Other:_____
2. How long have you lived there?_____
3. How old is the building you live in?_____
4. Do you have house plants? How many?_____
5. Do you sleep on a waterbed?_____
6. Do you use an electric blanket?_____
7. Do you drink tap or well water?_____
8. Do you have pets? Dogs_____ Cats_____ Indoor_____Outdoor_____
9. If you do have pets, what are their names?_____
10. Other:_____
11.Have you ever lived/ worked in a water damaged building (Flood/leaks)? Provide brief detail.

_____

_____

_____

12. Any signs of water staining, including cracked/peeled paint? Home Office

13. Has there ever been a water leak in your home? *(check all that apply)*

□Roof Leak
□Basement Flood
□Water Heater Leak
□Supply Line to refrigerator/Toilet
□Burst Pipe
□Broken Sprinkler Line
□Toilet/Bathtub Overflow
□Sewer Backup
□Gutter Backup
□Air-conditioning Leak
□Draw Pipe Leak Under Kitchen/Bathroom Sink
□Wash Machine Overflow
□Water Stain from Plants
□Other:_____

14. Do you have a swamp cooler?_____
15. What does your house use to Heat/Cool?

□Forced air □Radiant floor heat □Piped Hot Water □Other:_____

16. Has there ever been a water leak in your place of employment?_____
17. Do you walk/recreate/live near or swim in any bodies of water (lakes, backyard ponds etc.)? Have you ever seen any algae blooms or scum in the water? Provide brief detail.

_____

_____

18. Do you go fishing often? _____
19. Do you eat seafood? List fish you eat (sea bass, etc.)

_____

20. Do you have any history of a tick bite or spider bite? Please describe. _____

_____

Social History:	Y	N	P
Do you exercise regularly?			
Exercise type:_____Quantity:_____			
Do you participate in community events?			
Do you wear seatbelt when driving?			
Caffeine/pills/coffee/tea/energy drinks? Amount:_____ Frequency:_____			
Consume Alcohol? Amount:_____Frequency:_____			
Do you smoke/chew tobacco? Amount:_____ Frequency:_____			
Marijuana use? Frequency:_____			
Do you use other recreational drugs?			
Do you engage in risky behaviors?			
Road Rage?			
Do you engage in high risk sexual behavior?			
Have you ever been abused physically, emotionally, or sexually?			
Eating disorder (bulimia, anorexia, or compulsive eating)?			
Other:_____			

Family History

Where you adopted? Yes ☐ No ☐

Please list any health issues, which have affected your relatives; include their age or age at death

Mother: _____

Father:_____

Brothers: _____

Sisters: _____

Maternal Grandmother:_____

Maternal Grandfather:_____

Mothers siblings:_____

Paternal Grandmother:_____

Paternal Grandfather:_____

Fathers siblings:_____

List your children's names:

	Ages	Health
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sleep

□Witnessed apnea events during sleep greater than 10 seconds in duration
□Disruptive Snoring **□Gasping/Choking**
□Awaken with headache or dry mouth **□Mood Disorder,Fatigue, inability to concentrate**
□History of Heart Disease **□Hypertension/High Blood Pressure**
□History of Stroke or family history **□Craniofacial abnormalities**
□Upper Airway soft tissue abnormalities **□Disturbed or restless sleep**
□Diabetes **□Non-restorative sleep**
□Excessive Daytime Sleepiness

Sleepiness Scale *(Choose the most appropriate response for each situation)*	**Never would doze off**	**Slight chance of dozing**	**Moderate chance of dozing**	**High chance of dozing**
1.Siting and Reading	☐ 0	☐ 1	☐ 2	☐ 3
2.Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
3.Sitting inactive in a public place	☐ 0	☐ 1	☐ 2	☐ 3
4. As a passanger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
5. Laying down to rest in the afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
6. Sitting and talking with someone	☐ 0	☐ 1	☐ 2	☐ 3
7. Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
8. In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3

Score of All Questions (sum total of all eight responses):_____

1. How many hours per night do you sleep? _____ Do you take naps?_____
2. What Position do you sleep? *(circle one)* Back Side Stomach
3. Do you often feel tired, fatigued, or sleepy during the daytime? _____
4. Do you wake rested, refreshed, ready to go?_____
5. Do you need an alarm clock to wake? _____
6. Has anyone observed you stop breathing during your sleep?_____
7. Do you grind your teeth in your sleep?_____
8. Other:_____

Eating Habits	Yes	No

1. Do you eat dairy products? (milk, yogurt, cheese, etc.) …… ☐ ☐
2. Do you eat red meat? *Please circle*…… ☐ ☐
Beef Venison Lamb Pork
3. Do you eat fish or fowl? *Please circle.* …… ☐ ☐
Tuna Chicken Turkey
4. Eggs? *Please Circle*…… ☐ ☐
Free ranged or Caged
5. Commercially canned food…… ☐ ☐
6. Fruit or vegetable juice…… ☐ ☐
7. Refined cereals or products made with flour(pasta, bread)…… ☐ ☐
8. Vegetables and/or legumes…… ☐ ☐
9. Fruit? How many pieces per day?_____ …….. ☐ ☐
10. Whole grains (brown rice, millet, oats)…… ☐ ☐
11. Soy products (tofu, soy milk, tempeh)…… ☐ ☐
12. Alternative milk products (coconut, almond, hemp)…… ☐ ☐

Please note how often you consume the following items:
Spoons of sugar _____ Cookies/Cake _____
Pop/Soft drinks _____ Ice Cream _____
Pastries _____ Coffee _____

Please List EVERYTHING you Eat and Drink for Three Full Days

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Snacks			
Dinner			

Patient Name:_____Date:_____

Patient History – Timeline

In the space below, please provide a brief timeline in outline form of your own history. Begin with birth and childhood; please include any major illnesses, injuries, or hospitalizations up to the present time. Be sure to list any significant turning points or major events in your line; include any periods of heavy usage of alcohol, cigarettes, coffee, and pharmaceutical or recreational drugs. **WOMEN ONLY:** please include events related to your reproductive system such as first period, pregnancies, abortions, birth control, menopause, etc. If you are filling this out for your child, please include notable information about the pregnancy and nursing.

☙ Allergies ❧

Allergies: **(drugs, food, environmental)**	**Symptoms / Severity of Reaction:** **(please state if any reactions have been life-threatening)**

☙ Medication and Supplement Intake Form ❧

Prescription Medications:	Dose (Frequency and Route)	Length of Use	Reason for drug & Any Reactions?	Date Stopped	Do you take Consistently (Y/N)

Patient Name:_____Date:_____

Vitamins/Herbs/ Supplements with brand (currently taking)	Dose (Include route)	Frequency	Start Date	Reason for taking, any reactions, compliance	Date Stopped	Do you take Consistently (Y/N)

Patient Name:_____Date:_____

℘ Imaging and Screening History ☙

To be filled out by your provider, unless you are aware of the following results/genes

EBT Heart Scan:

Date	Results	Date	Results	Date	Results

Pulmonary Nodules:

Date	Results	Date	Results	Date	Results

Carotid U/S:

Date	Results	Date	Results	Date	Results

Colonoscopy:

Date	Results	Date	Results	Date	Results

Mammogram:

Date	Results	Date	Results	Date	Results

Pap (F):

Date	Results	Date	Results	Date	Results

PSA/DRE (M):

Date	Results	Date	Results	Date	Results

Thyroid:

Date	Results	Date	Results	Date	Results

Other: Date/Results Date/Results

Endoscopy: _____ _____ **Bone Density**: _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Abdominal Imaging: _____ _____
_____ _____
_____ _____

Genetics:

Gene's	Date	Results	Related Performance Markers
HLA (Biotoxin)			
HLA (Celiac)			
HLA B27			
MTHFR (C677T)			
MTHFR (A12986)			
Factor V Leidien			
Prothrombin			
Von Wiillerbands			
Other:			