Patient Information Form for Dr. Dunal's Office

Please bring this completed form with you to your appointment

Name ____ Date of Birth______________

Address: ____

City: ___________________________________ State _______ Zip ______________

Phone (H): _______________ (W): ____________________ (C): _________________

Where do you prefer that we try first? ○ Home ○ Work ○ Cell
E-Mail: ____
Would you like to receive emails about health-related topics? ○ Yes ○ No Thanks

Social Security Number: ______________________________
Birthdate: ____ ○ Female ○ Male
Marital Status: _________________________

Employer____
Employer's Address: ____
City: ___________________________________ State _______ Zip ______________

Do you have Medicare? ○ No ○ Yes

Spouse's or Parent's Name: ___________________________ Phone: ______________
Emergency Contact Person: ___________________________ Phone: ______________
Relationship to Patient: ____

May we ask how you found us? ____

AUTHORIZATION AND RELEASE I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payors such as insurance companies, and/ or health practitioners if I request it. I understand that my insurance carrier may reimburse me for less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or to my dependent.

____
Signature of Patient (or Parent if minor) *Date*

OPTIONAL RELEASE
I give my permission for Dr. Dunal and/or her staff to discuss my medical condition and/ or test results with the following person(s)______________________________________
____

Signature ____ Date __________________
Witness ____ Date __________________

*Name*_________________________

ABOUT YOUR HEALTH

Describe your overall health: ______________________________

Describe your health challenges: ______________________________

What have been the major heath-related/illness events in your life? What else was going on at the time?

Event: (illness, surgery, etc.)	Circumstance: (Example: move, started new job, birth of child, etc.)

Dates of Surgeries / Hospitalizations / Injuries (*if not listed above*):

DIAGNOSED HEALTH CONDITIONS

○ Hypertension	○ Diabetes	○ Asthma	○ Cancer	○ Depression
○ Heart Disease (type)	○ Thyroid Disease	○ Sinusitis	○ Basal Cell Cancer	○ Anxiety
	○ Rheumatoid Arthritis	○ Lung condition	○ Ulcer	○ Bipolar
○ Stroke	○ Other Autoimmune Condition	○ Headaches	○ Reflux	○Addiction
○ Clotting Disorder		○ Migranes	○ Colitis	○ Panic Attacks
○ Varicose Veins	○ Celiac Disease	○ Incontinence	○ Arthritis	○
○ Vascular Disease	○ HIV/AIDS	○ Hepatitis	○ Joint Pain	○

Allergies: ______________________________

Other: ______________________________

(*Women*) # of Pregnancies: ______ Number of Children: _____ # Vaginal: ______ # C-Section: ______

Last period / Menopause: ________

Prescription Medications / Why? ____

____

____

____

Supplements & Vitamins / Why? ____

____

____

____

ABOUT YOUR FAMILY

Age / and what conditions do or did they have?	*Any family history of?*
Mother: ____________________	○ Addictions
Father: ____________________	○ Alzheimer's
Brothers: ____________________	○ Arthritis
Sisters: ____________________	○ Autoimmune Disease
Sons: ____________________	○ Cancer (What type?) __________
Daughters: ____________________	○ Colitis / Irritable Bowel
Grandparents ____________________	○ Diabetes
Relatives with relevant conditions: ____________________	○ Dementia
	○ Heart Disease / Heart Attack
	○ High Blood Pressure
	○ Mental Illness
	○ Migraines
	○ Osteoporosis
	○ Stroke
	○ Thyroid Disease
	○ Sickle-Cell Anemia
	○ Other: __________

ABOUT YOU

Where are you from? ____

Where else have you lived? ____

International travel? ____

____

Are you: ○ Single ○ Partnered ○ Married ○ Separated ○ Divorced ○ Widowed

Do you live: ○ Alone With: ______________________________

Children / Ages ______________________________

Pets? ______________________________

Do you like your living circumstances? ______________________________

Education: ○ Student now ○ High School ○ College ○ Post-Grad

Specialized training or other studies: ______________________________

Degrees or area of expertise: ______________________________

Current occupation: ______________________________

Do you like your job? ______________________ Travel time: __________

Previous occupations: ______________________________

Significant toxic exposures: ______________________________

ABOUT YOUR LIFESTYLE

SLEEP

Sleep _____ hours a night ○ Broken sleep because: ______________________ ○ Naps?

○ Use sleep aid(s): ______________________________

○ Wake feeling rested ○ Remember my dreams ○ Lucid dreams ○ Restless legs ○ Snore

EXERCISE

Everyday life is predominantly: ○ Active ○ Sedentary ○ Mixed

Exercise approximately _____ hours per week

Describe your exercise regimen. *What types of exercise, for how long, and how many times a week, etc:*

OTHER

Are you sun-aware? ○ Sunscreen ○ Hat ○ Sunglasses

What are your hobbies?: ______________________________

Do you meditate? ______________________________

WHAT YOU DRINK/EAT

Daily glasses of water: _____ ○ Tap ○ Bottled ○ Purified

Daily amount of caffeine: Coffee_____ Lattes_____ Diet sodas_____ Sodas_____ Tea _____

Energy drinks _____ Chocolate _____ When is latest one in the day? _____

I usually eat _______ meals a day ○ Good appetite? ○ Enough fiber?

Palm-sized servings per day of ______ Proteins What kinds? ______________________

Fist-sized servings per day of: _____ Fruits _____ Vegetables ○ Vegetarian?

Servings of complex carbohydrates and grains ________ ○ Avoid gluten?

Processed foods: ○ Mostly ○ Partly ○ Minimal ○ None

Restaurant foods: ○ Mostly ○ Partly ○ Minimal ○ None

Organic foods: ○ Mostly ○ Partly ○ Minimal ○ Not feasible

How many/kinds of sweets a day? ______________________________ ○ Baked Goods ○ Dark Chocolate

Other: ____

Typical Breakfast: ____

Snack? ____

Typical Lunch: ____

Snack? ____

Typical dinner: ____

Snack? ____

Any nutritional concerns? ____

HABITS

○ Smoke now ○ Smoked ______ Years Ago for ______ years ______ Packs a day ○ Want to quit

○ Alcohol Type: ______________________ _______ Drinks/oz. a day ○ More in past ○ Want to quit

○ Recreational drugs: ____

OVERVIEW

Major stress is from: ____

Who or what supports you? ____

Who or what aggravates you? ____

What do you do for yourself? ____

What are your most pressing health concerns?

1: ____

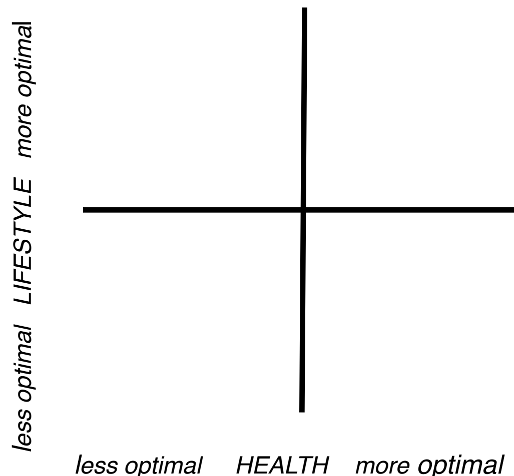
2: ____

3: ____

4: ____

Where do YOU fit on this chart?

(Key: lifestyle increases bottom to top
health increases right to left
on this chart)



REVIEW OF SYMPTOMS (Partial Fills OK)

General: ○ Chronic fatigue ○ Weakness ○ Anemia ○ Weight problems ○ Dieting ○ Food cravings ○ Sensitive to heat / cold ○ Fluid Retention ○ Bruise easily ○ Lymph node swelling	Ears: ○ Hearing loss ○ Pain ○ Ringing in ears ○ Wax ○ Dizziness - room spinning ○ Dizziness - lightheadedness ○ Pressure	Cardiac: ○ High blood pressure now or past ○ Palpitations ○ Heart murmur ○ Mitral valve prolapse ○ Chest pain at rest or exercising ○ Trouble breathing lying flat ○ Pain in arms or jaw ○ Nausea ○ Blood clots ○ Varicose veins
Skin: ○ Rashes ○ Itching ○ Cysts ○ Unusual moles or marks ○ Discolorations ○ Dry/Oily skin ○ Eczema ○ Skin cancer history ○ Rosacea ○ Psoriasis ○ Sores that don't heal	Nose: ○ Always runny ○ Always stuffy ○ Nosebleeds ○ Post nasal drip ○ Sinus problems ○ Allergies ○ Difficulty breathing through nostrils ○ Unusual smells ○ Loss of smell ○ Sneezing ○ Snoring	Gastrointestinal: ○ Poor appetite ○ Nausea ○ Vomiting ○ Reflux ○ Heartburn ○ Indigestion ○ Gas ○ Bloating ○ Diarrhea ○ Abdominal pain ○ Constipation ○ Black stools ○ Blood in stools ○ Abnormal stools ○ Hemorrhoids ○ Rectal pain ○ Sensitivity to certain foods
Head: ○ Headaches ○ Migraines ○ Facial pain ○ Concussions ○ History of head injury ○ Pressure ○ Memory loss ○ Dyslexia Nerves: ○ Pinched ○ Numbness	Throat and Mouth: ○ Hoarseness ○ Coated Tongue ○ Sore ○ New lumps or bumps ○ Difficulty swallowing ○ TMJ dysfunction ○ Jaw clicks ○ Teeth grinding ○ Mouth ulcers ○ Dental problems ○ Bad breath ○ Receding gums ○ False teeth ○ Gum disease ○ Mercury fillings ○ Mercury fillings removed	Urinary: ○ Kidney stones ○ Frequent urination ○ Painful urination ○ Wake up then can't go ○ Can't get to bathroom quickly Enough ○ Frequent Infections ○ Feel full, can't urinate ○ Have to go, little urine ○ Leaking urine -- Circumstances?
Eyes: ○ Vision changes ○ Pain ○ Blurry / double vision ○ Floaters ○ Sensitivity to sunlight ○ Flares ○ Excess tearing or pus ○ Glasses ○ Contact lenses ○ Lasix ○ Cataract surgery ○ Glaucoma ○ Colorblind	Lungs: ○ Wheezing ○ Shallow breathing ○ Shortness of breath with / without exercise or cold ○ Cough -- dry ○ Cough -- mucous ○ Cough -- blood ○ Pain with deep breath	Musculoskeletal: ○ Joint Pain ○ Arthritis ○ Broken bones ○ Injuries ○ Surgeries ○ Joint injections ○ Muscle cramps ○ Back pain ○ Repetitive motion trauma ○ Numbness ○ Tendonitis

Women:	Men:	Predominant Moods:
○ Age period started ____ ○ Period lasts ____ days ○ ____ Days between cycles ○ Abnormal bleeding ○ Discharge ○ Itching ○ Sores ○ Herpes ○ Sexually transmitted diseases ○ Use condoms? ○ PMS ○ Mood swings ○ Fluid retention ○ Painful periods ○ Cramping ○ Pain with sex ○ PCO ○ Lower abdominal pain ○ Skipped periods ○ Hot Flashes ○ Incontinence Mother's Menopause Age: ____ Menopause? at age: ____	○ Discharge ○ Itching ○ Sores ○ Lumps ○ Herpes ○ Sexually transmitted diseases ○ Use Condoms ○ Drip / Dribble ○ Trouble starting stream ○ Erectile dysfunction ○ Monthly testicle self-exam ○ Epididymitis ○ Infertility	○ Spiritual ○ Peaceful ○ Cheery ○ Content ○ Optimistic ○ Apathetic ○ Pessimistic ○ Angry ○ Anxious ○ Restless ○ Manic ○ Melodramatic ○ Road rage ○ Panic easily ○ Lonesome ○ Melancholic ○ Extreme stress ○ Isolated ○ Overwhelmed ○ Family history of psychological problems ________

HEALTH SCREENINGS

What is the date of your last screening test on the list below? | Your last immunization?

○ Pap Smear	○ Colonoscopy	○ Tetanus
○ Mammogram	○ Eye Exam	○ Flu
○ Dexa Scan (bone density)	○ Dental Exam	○ Pneumonia shot
○ PSA	○ Dental Cleaning ____ # Times a Year	○ Hepatitis
Do you do monthly self-exams?	○ Annual Labs	○ Shingles
	○ Annual Physical	○ HPV (Gardasil)

Travel Shots: ____

Questions or topics we haven't discussed? ______________________________

Please remember to bring all medications and supplements you are taking to your first appointment.

THANK YOU FOR HELPING US GUIDE YOU TOWARD OPTIMAL HEALTH

What did you think of this questionnaire? ○ *Helpful* ○ *Useful* ○ *Interesting* ○ *Tedious* ○ *Other*