Balanced Integration, LLC

Patient Questionnaire

Please **TYPE**						
Name:				Date:		
Address:				Home #:		
City:	State:	Zip:		Cell or work #:		
Sex:	Age:	**Date of Birth:**		Physician's #:		
Email Address (**Please provide some sort of email contact**):						
Physician's Name:						
Physician's Address:						
Marital Status:	Single	Married	Remarried	Divorced	Widowed	Separated
How Many Yrs						
Primary Occupation:		Location:		Years:		
Previous/ other occupations, hobbies:						
Exposure to hazardous material: Yes No		Type:				
Spouses Name:		Spouses Occupation:				
Children Names:						
Ages:						
What is the chief Problem that brings you to see Dr. Pryce (attach a sheet if you need more space)						
1.						
How long have you had this problem or when was it diagnosed:						
What do you think might be causing it:						
2.						
How long have you had this problem or when was it diagnosed:						
What do you think might be causing it:						
3.						
How long have you had this problem or when was it diagnosed:						
What do you think might be causing it:						

4.
How long have you had this problem or when was it diagnosed:
What do you think might be causing it:

PAST MEDICAL HISTORY: **Please do NOT skip this section**

Year	Illness or Operation	Complications

Have you had any blood transfusions: Yes No	Dates:

FAMILY HISTORY: If deceased, please list age at death and cause of death

	Living (L) Deceased (D)	Age	Known medical conditions or cause of death **Please do NOT skip this section**
Spouse:			
Children:			
Mother:			
Father:			
Sisters:			
Brothers:			

FAMILY HISTORY of any of the following in a blood relative: parent, grandparent, sibling, aunt, uncle, etc

Stroke	Tuberculosis (TB)	Breast Cancer	Kidney Disease
Heart Attack/ Angioplasty	Asthma/ Emphysema	Other Cancer	Nervous Breakdown
Heart Surgery	Glaucoma	Colon Polyps	Alcoholism
High Blood Pressure	Arthritis	Thyroid disease	Migraine Headaches
Diabetes	Liver problems	Kidney stones	Epilepsy
Aneurysm	Colon Cancer	Kidney Failure	Other Problems

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FAMILY HEALTH HISTORY These questions pertain to only your **Parent, Grandparent or Sibling's** health history. Please answer place and 'X' if it applies to one of these relatives. If you are unsure then leave it blank.

	Sibling(S)	Parent(S)	Grandparent (S)
Family history of cancer or neoplasia			
Family history of arthritis/joint disease (osteoporosis, etc)			
Family history of allergy or autoimmunity			
Family history of dementia			
Family history of depression or mental illness			
Family history of diabetes			
Family history of hypertension			
Family history of heart disease			
Family history of thyroid/ endocrine disease			
Family history of kidney disease			
Family history of Stroke			
Family history of Heart Attack			
Other (specify)			

ETHNICITY: Please circle only **ONE**

Eurasian	North Central Asian	South East Asian	Black	North African
Northern European	Central European	Southern European	Native American	Middle Eastern
Hispanic	Western European	Mixed (African/ Asian)	Mixed (Caucasian/Asian)	Mixed (Caucasian/ African)

Prescription MEDICINES: LIST ONLY THE ONES THAT YOU HAVE BEEN TAKING RECENTLY. (Please bring all medicines with you to your appointment)

Medication	Dose (mg)	Date started	Date stopped	Medication	Dose (mg)	Date started	Date stopped
1.				5.			
2.				6.			
3.				7.			
4.				8.			

SUPPLEMENTS/ OVER THE COUNTER: LIST ONLY THE ONES THAT YOU HAVE BEEN TAKING RECENTLY. (Please bring all supplements with you to your appointment)

Supplement	Dose (mg)	Date started	Date stopped	Supplement	Dose (mg)	Date started	Date stopped
1.				5.			
2.				6.			
3.				7.			
4.				8.			

Have you used any recreational drugs? Yes No	Kind:	

ALLERGIES or reactions to medicines, food, supplements, or environmental substances.

MEDICATION/ SUBSTANCE	REACTION	Date

PREVIOUS STUDIES: list the date it was performed. (please FAX: 443-256-0330 recent tests results and interpretations of X-rays PRIOR to your office visit)

Chest X-ray	Biopsy of:	Colonoscopy
Pulmonary function	Gallbladder	Colon/Barium Enema
Bronchoscopy	Ultrasound of:	Kidney IVP
EKG	Gastroscopy	CAT scan of head
Echocardiogram	Stomach/UGI	CAT scan of other
Stress Test	Cystoscopy	MRI
Mammogram	Protosigmoidoscopy	Other

PERSONAL HABITS:

Tobacco: Yes No	Have you ever Smoked: Yes No		
Type and Amount	Years:	If Stopped, When?	
Have you tried to stop? Yes No	Do you wish to stop? Yes No		
Alcohol: Amount (including beer ,wine, and liquor)			
Have you felt the need to cut down on alcohol?	Yes	No	
Do you feel guilty about the amount of alcohol used?	Yes	No	
Have you had a problem with alcohol?	Yes	No	
Have you had a drink in the last 24 hours?	Yes	No	

Amount per day	Coffee	Tea	Carbonated Beverages

Travel in the last 2 years (Where and When)

DIET (any special diet or change in eating habits)

Please list what you typically have during each meal:

Meal	yes	NO	typical
Breakfast			
Snacks			
Lunch			

Dinner			

Water intake in ounces per day:

HEALTH HISTORY These questions pertain to only **YOUR** health history. Please answer yes or no. If you are unsure then leave it blank. (some questions may be repeated in several sections- please answer)

Integumentary System (hair, nails, sweat glands and sense receptors)		
Do you suffer from or have:	**Yes**	**No**
Hair Loss?		
Poor Hair/ Nail growth?		
Any skin disorder such as acne, rosacea, or eczema?		
Wrinkles or stretch marks?		
Itchy, red or inflamed skin?		
Dry Skin?		
Vision problems? If yes, please specify:_____		
Hearing problems? If yes, please specify:_____		
Circulatory System		
Do you suffer from, have or have had:	**Yes**	**No**
Poor Circulation?		
High Cholesterol?		
High Blood Pressure?		
Rapid Heart Beat?		
Stroke?		
Heart Attack?		
Bruise easily?		
Anemia?		
Hemophilia?		
Structural System (Skeletal, Muscles, Joints)		
Do You have/ suffer from or are prone to:	**Yes**	**NO**
Osteoporosis/ Osteopenia?		
Chronic Fatigue Syndrome or Fibromyalgia?		
Osteoarthritis?		
Athletic injuries, strained knees, elbows?		
Stiffness or swelling of the joints and or muscles?		
Muscular twitching or jerking of the limbs?		
Restless leg syndrome?		
Gout?		
Tooth decay, loss or toothaches?		
Loss of balance or coordination?		

How often do you exercise?	**Sedentary (little to no exercise)**	**Lightly (1-3 days/wk)**	**Moderately (3-5X/wk)**	**Very Active (6-7X/ wk)**	**Athlete (2X/ day)**

Little/none	1-3 days/ wk	3-5 days per week	6-7 days per week	2X daily
What Type of exercises?				

Respiratory System		
Do you have / Suffer from:	**YES**	**NO**
Asthma?		
Current diagnosis of COPD (chronic Obstructive Pulmonary Disease) or Emphysema?		
Bronchitis or pneumonia?		
Chronic sinus or ear infections?		
Do You Smoke?		
Are you exposed to second hand smoke?		
Immune and lymphatic System		
Do you have / Suffer from:	**YES**	**NO**
Do you currently have Cancer? If Yes, please specify:		
Have you had cancer in the past? If Yes, please specify:		
Are you prone to colds or infections?		
Do you suffer from any inflammation?		
Digestive and Intestinal System		
Do you have / Suffer from:	**YES**	**NO**
Crohn's Disease?		
Colitis?		
Any issues with malabsorption?		
Chronic diarrhea?		
Chronic constipation?		
Diabetes?		
GERD (Gastroesophageal Reflux Disease)?		
Obese/ Overweight?		
Abdominal bloating, distension, or indigestion?		
Excessive gas, or belching after meals?		
Small ulcers or canker sores in the mouth?		
Taken antibiotics in the last 2 years?		
Jaundice, Hepatitis, or cirrhosis?		
Gallbladder removed?		
Difficulty swallowing capsules?		
Urinary, Glandular (Endocrine System), and Reproductive System		
Do you have/ suffer from:	**Yes**	**NO**
Adrenal fatigue		
Frequent Bladder Infections (UTI's)?		
Hyper or Hypothyroidism? If yes, please specify:		

Lost or diminished Sex drive?		

Nervous System		
Do you have/ suffer from:	**Yes**	**NO**
Alzheimer's/ Dementia?		
Parkinson's Disease?		
Numbness or tingling?		
Multiple Sclerosis?		
Epilepsy or prone to seizures?		
Autism spectrum disorder (ASD)?		
Poor memory?		
Mental aberrations or schizophrenia?		
Irritability, anxiety, nervousness, or depression?		
Insomnia?		
Paranoia, delusions, or hallucinations?		

History of:	**YES**	**NO**	**History of**	**YES**	**NO**
Cancer or Neoplasia			Low grade infection		
Heart or artery disease			Depression		
Bowel or digestive disease			Liver disease		
Urinary or renal disease			Thyroid disease		
Skin disease or atopia			Diabetes		
Allergy or autoimmunity			Arthritis or Joint disease		
Chronic fatigue					

Do you have any of the Following?					
	Yes	NO		Yes	NO
Recent Weight Gain (amount)?			Falls, imbalance or difficulty walking?		
Recent Weight Loss (amount)?			Loss of consciousness, fainting, or convulsions?		
Fever or Soaking Sweats at night?			Problem with vision or eyes?		
Fatigue?			Head or ear noise?		
Weakness, numbness, tingling, cramps at night of legs or arms			Change in hearing?		
New frequent or severe headaches?			Change in speech or voice?		
Dizziness (spinning or lightheadedness)?			Sore tongue, mouth, or dental problems?		
Frequent or severe nosebleeds?			Daily cough or cough with bloody		

			phlegm?		
Short of breath when in a hurry or walking up 2 flights of stairs?			Swelling of the ankles everyday?		
Short of breath sitting or reclining?			Discomfort or pain in chest?		
Pain or tiredness in the legs while walking?			Any leg or foot discomfort at night?		
High blood Pressure			Years:		
Recent Blood Pressure					
	YES	No		YES	NO
Abdominal pain?			Frequent heartburn or indigestion?		
Change in bowel habits?			Black or bloody bowel movements		
Difficulty urinating?			Do you lose control of urine at times?		
Awaken at night more than once to urinate?			Sexual problems or change in sex drive?		
Do you have any discharge?			Any changes in skin (moles, rash, other)		
Persistent painful, stiff, or swollen joints?			Back discomfort?		
Do you enjoy your work?			How many people are in your household?		
Any stress or frequent conflicts at home?			Do you feel anxious or depressed much of the time?		
Are you seriously considering suicide?			Difficulty sleeping?		
History of hospitalization for an emotional problem?					
GENDER SPECIFIC					
WOMEN			MEN		
History of heavy menses/ menorrhagia			History of prostatic enlargement or BPH		
History of PMS			History of Erectile Dysfunction		
History of peri-menopause or menopause					
Are your menstrual periods normal					
Date of last menstrual period					
Bleeding between periods or after menopause?					
Are you currently pregnant or trying to get pregnant?					
Are you unable to have children because of sterility (not because of age or an operation)?					
Are you currently breast feeding?					
Do you have PCOS (Polycystic Ovarian Syndrome)?					

Do you have endometriosis or uterine fibroids?					
Have you had your uterus and/or ovaries removed?					
Do you have chronic yeast infections?					
Any hot flashes?					
Any pain or dryness with intercourse?					
Any breast discharge?					
Do you have excess hair on your face/arms/legs?					
Number of pregnancies?	Deliveries	Miscarriages	Abortions		
Approximate date of last PAP smear?					
Have you used hormones?					
HAVE YOU HAD:					
Asthma	Rheumatic fever	Ulcers	Aids or HIV testing		
Pneumonia	Diabetes (years)	Stroke	Sexually Transmitted disease		
Tuberculosis	Hepatitis	Migraines or severe head pain	Radiation or chemotherapy		
Polio	Kidney Infection	Phlebitis or blood clots	Skin Cancer		
Thyroid trouble	Kidney stones	Herpes	Cancer		
Heart Attack (yrs)	Bladder infection	Gonorrhea	Other		
Heart Murmur	Syphillis				
Have we left out anything that you are concerned about or feel is important about your health?					
Patient (signature)					