

# Ingels Family Health

2425 Post Road, Ste. 100, Southport, CT 06890  
Phone 203.254.9957 Fax 203.254.9343

851 Fremont Avenue, Ste. 104, Los Altos, CA 94024  
Phone 650.229.1010 Fax 650.229.1011

Date: \_\_\_ / \_\_\_ / \_\_\_

*Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the **Comments Section**. Thank you.*

Name:		Social Security Number:		
Address:		City/State/Zip:		
Home Phone:	Work Phone:	Cell Phone:		
Email address:				
Date of Birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height: “	Weight:
Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Living with Partner-Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Town of Birth:
Employed by:		Occupation:		
Spouse/Partner Name (Parent's name if patient is a minor):		Names and Ages of Children:		
Insurance Company/Policy Number				
Primary Care Physician:	Phone:	Please tell us how you found out about this office:		
Emergency Contact Name:	Phone:			

What is the chief complaint(s) you are seeking treatment for today? \_\_\_\_\_

When did this problem begin? What caused it? \_\_\_\_\_

Have you ever had this problem or a similar problem before? If yes, please explain: \_\_\_\_\_

To what extent does this problem interfere with your daily activities (your home life, work, social life, exercise, sleep, sex)? \_\_\_\_\_

Have you ever received treatment for this problem? If so, what type? \_\_\_\_\_

When? \_\_\_\_\_ By Whom? \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

What were the results of the treatment(s)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications:** Please list all prescription and over-the-counter medications taken in past 2 years.

Name	Dose	Current	Date Discontinued	Adverse Reactions

**Drug Allergies** \_\_\_\_\_

**Supplements:** Please list all vitamins, minerals, herbs and other supplements taken in past 2 years.

Name	Dose	Current	Date Discontinued	Adverse Reactions

**Allergies:** Foods \_\_\_\_\_ Dust Mold Trees Grasses Weeds Others \_\_\_\_\_

**Hospitalizations and Traumas:** Please include surgeries, auto accidents, etc.

Type	Date	Complications

**Dental History:** Amalgam (Silver) fillings (#) \_\_\_\_\_ Composite fillings \_\_\_\_\_ Crowns \_\_\_\_\_ Bridges Y N

Fluoride treatments \_\_\_\_\_ Other \_\_\_\_\_ Who is your dentist? \_\_\_\_\_

**Diet History:**

Do you have any dietary restrictions? \_\_\_\_\_  
 Are you a:   vegan   vegetarian   lactoovovegetarian  
 How much of the following do you drink in a day?   Water \_\_\_\_\_   Juice \_\_\_\_\_   Soda \_\_\_\_\_  
 Coffee (Regular) \_\_\_\_\_   Coffee (Decaf) \_\_\_\_\_   Tea \_\_\_\_\_   Alcohol (list type) \_\_\_\_\_  
 How do you feel after you eat?   Better   Worse   No change   Fatigued  
 Do any specific foods make you feel worse? \_\_\_\_\_  
 Do you crave any specific foods? \_\_\_\_\_  
 Do you snack during the day? If so, what foods do you eat? \_\_\_\_\_  
 List your typical: Breakfast \_\_\_\_\_  
                                   Lunch \_\_\_\_\_  
                                   Dinner \_\_\_\_\_

**Lifestyle History:**

Do you smoke? Yes No How often? \_\_\_\_\_ How long have you smoked? \_\_\_\_\_ years  
 Have you ever smoked? Yes No When did you quit? \_\_\_\_\_ How many packs a day? \_\_\_\_\_  
 Do you or have you ever used recreational drugs? Yes No Which ones? \_\_\_\_\_  
 Do you exercise? Yes No How often? \_\_\_\_\_ Which exercises? \_\_\_\_\_  
 How many hours do you work in a day? \_\_\_\_\_  
 Please rate your level of stress on a scale of 1 to 10 (10 is highest) \_\_\_\_\_  
 Please describe your stressors \_\_\_\_\_  
 How many hours of sleep do you get each night? \_\_\_\_\_  
 What time do you go to bed? \_\_\_\_\_ What time do you wake in the morning? \_\_\_\_\_  
 How would you rate your quality of sleep? Great Good Fair Poor

**Past Medical History:**

**Please circle if you have received any of the following vaccines:** MMR DPT Hepatitis B Chicken pox  
 Hib (Hemophilus influenzae) Polio HPV (Gardasil) Pneumococcus Hepatitis A Typhoid  
 Yellow fever Meningitis Flu (Influenza virus) Other \_\_\_\_\_ **Adverse Reactions** \_\_\_\_\_

**Have you ever had any of the following illnesses?**

Allergies	Y	N	Eye disorders	Y	N	Mental disorders	Y	N
Anemia	Y	N	Fibromyalgia	Y	N	Mononucleosis	Y	N
Asthma/Bronchitis	Y	N	Heart murmur	Y	N	MCS	Y	N
Bone or joint disorders	Y	N	Hepatitis	Y	N	Muscle disease	Y	N
Cancers, leukemia, lymphoma	Y	N	Herpes	Y	N	Neurological disease	Y	N
Celiac disease/Gluten intoler.	Y	N	High blood pressure	Y	N	Psychiatric disease	Y	N
Chronic fatigue	Y	N	Hypoglycemia	Y	N	Sinus infections	Y	N
Crohn's disease	Y	N	IBS	Y	N	Skin problems (eczema)	Y	N
Depression	Y	N	Kidney/Bladder problems	Y	N	Thyroid disorders	Y	N
Diabetes	Y	N	Liver disease	Y	N	Other:	Y	N

**Family Medical History:**

Mother: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_  
 Father: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_  
 Siblings (Bro/Sis): Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_  
 Siblings (Bro/Sis): Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_  
 Siblings (Bro/Sis): Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_  
 Siblings (Bro/Sis): Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_  
 Maternal Grandmother: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_  
 Maternal Grandfather: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_  
 Paternal Grandmother: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_  
 Paternal Grandfather: Living: Age \_\_\_\_\_ Deceased: Age \_\_\_\_\_ Health Issues \_\_\_\_\_

**HEAD & FACE**

- Headaches  
Location \_\_\_\_\_
- Throbbing / Burning/ Sharp / Ache
- Constant / Intermittent
- Dull / Severe
- Frequent / Irregular
- Worse with menstrual cycle
- Worse in Winter/Spring/Summer/Fall
- Worse in hot/cold weather
- Worse night time/daytime
- Aggravated by smells
- Migraines
- Dizziness
- Facial pain
- Poor memory
- Cloudy thinking
- Poor Concentration
- Confusion
- Other

**EYES**

- Poor vision / glasses
- Night blindness
- Blind field
- Spots in front of eyes
- Eye pain
- Eye strain
- Eyes dry/itchy
- Excessive tearing
- Sensitive to light
- Other

**EARS**

- Poor Hearing
- Ringing in ears
- Recurrent earaches/infections
- Eruption in/around ears
- Sensitive to noise
- Itchy ears
- Drainage from ears
- Other

**NOSE**

- Frequent colds
- Sinus congestion
- Sinusitis
- Nose bleeds
- Post nasal drip
- Nasal discharge
- Loss of smell
- Sensitive to smells
- Itchy nose
- Sneezing
- Other

**MOUTH**

- Gum sores/bleeding
- Dental decay
- Grinding teeth
- Canker sores
- Jaw clicking
- Unusual tastes
- Bad breath
- Other

**THROAT**

- Recurrent sore throat
- Hoarseness
- Difficulty swallowing
- Lump in throat
- Cough chronic/seasonal
- Itchy throat
- Other

**RESPIRATORY**

- Chronic cough
- Coughing blood
- Asthma/wheezing
- Short of breath with exertion
- Short of breath without exertion
- Short of breath when lying down
- Phlegm
- Chronic bronchitis/pneumonia
- Difficulty breathing
- Other

**CARDIOVASCULAR**

- High blood pressure
- Low blood pressure
- Fainting
- Chest tightness
- Chest pain
- Heart palpitations
- Irregular heartbeat
- Rapid heartbeat
- Cold hands/feet
- Overall cold body temperature
- Overall warm body temperature
- Swelling of hands / ankles
- Other

**GASTROINTESTINAL**

- Excess thirst
- Never thirsty
- Excess appetite
- Never hungry
- Weight gain sudden/chronic
- Weight loss sudden/chronic

- Food cravings
- Food aversions
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in stool
- Undigested food in stool
- Urgent bowel movements
- Hemorrhoids
- Belching / Gas
- Heartburn
- Abdominal pain Stomach/Intestines
- Abdominal bloating
- Other

**URINATION**

- Frequent
- Urgent
- Difficult
- Painful
- Scanty
- Blood in urine
- Incontinence
- Kidney stones
- Wake at night to void
- Other

**MUSCULOSKELETAL**

- Neck stiff/pain
- Shoulder stiff/pain
- Back ache/stiff/pain
- Elbow stiff/pain
- Hand/wrist stiff/pain
- Hip pain
- Knee stiff/pain
- Foot/ankle stiff/pain
- Muscle aches
- Muscle weakness
- Muscle cramps
- Stiff joints
- Swollen joints
- Arthritis
- Bursitis
- Other

**NEUROLOGICAL**

- Nervousness
- Tremors
- Convulsions
- Numbness/Tingling
- Nerve pain/Neuralgia
- Seizures
- Learning disabled
- Other

