

2. What impact has this had on your life and family?

3. Please list any fears or concerns you may have in facing these problems.

4. Please list all medications and dosages you are taking.

Please indicate if you have taken antihistamines or steroids for a prolonged period of time.

5. Please list all medications you are allergic or sensitive to, and the reactions you have had as a result of taking these medications.

6. Please list all hospitalizations, reason, and approximate dates. Include operations, maternity, psychiatric, etc. List any blood transfusions or blood products you have received.

7. Have you ever been told any of the following? Please check:

- a. Your complete physical exam is negative_____
- b. All of your laboratory tests are negative_____
- c. Your problems are emotional or psychological, not physical ones_____
- d. Your health problems are from stress: Social_____ Marital_____ Family_____ Job_____ School_____
- e. There is no organic basis for your symptoms_____
- f. You must learn to live with your symptoms_____

8. Have you ever been diagnosed or are you concerned about the following?

Alcoholism_____	Hepatitis_____	Psoriasis_____
Cancer_____	Hypoglycemia_____	Tuberculosis_____
Diabetes_____	Mononucleosis_____	Sexually transmitted disease_____
Emphysema_____	Multiple Sclerosis_____	Herpes_____
HIV/ AIDS_____	Other diseases:_____	

9. Please list any names of allergy or environmental providers you have seen in the past.

Indicate names and dates of any antigens you have taken. Include any anaphylactic reactions or severe allergy reactions to testing or treatment.

10. Please check off areas that you have sensitivities to according to skin testing.

Pollens_____	Dust/Mites_____	Chemicals_____
Molds_____	Grasses_____	Animals_____
Feathers_____	Foods_____	Insects_____
Other_____		

11. Does the weather affect your health: YES_____NO_____

Type of effect if yes:_____

12. Are your symptoms seasonal? YES_____NO_____

If yes, which season(s) are worse?_____

13. Do your symptoms peak at a particular time of day or improve at a certain time of day?

If YES, which Time:_____

NO_____

14. Have you traveled anywhere and felt symptom relief or symptom progression?

If YES where? _____

15. Please fill out this **Review of Systems** as completely as possible. Detail if symptoms have been past or present.

SKIN

Itching_____	Tingling/Burning sensation_____	Athlete's foot_____
Flushing_____	Fungus in skin or nailbeds_____	
Rash_____	Dryness_____	Boils_____
Hives_____	Oiliness_____	Shingles_____
Eczema_____	Seborrhea (dandruff)_____	Other_____
Acne_____	Vasculitis_____	

EYES

Redness_____	Dryness_____	Double vision_____
Itching_____	Tearing_____	Spots before eyes_____
Blurred vision_____	Light sensitivity_____	Wear glasses/lenses_____
Crusted lids_____	Eye pain_____	Mucus discharge_____
Puffy eyes_____	Eyelid twitching_____	Other_____

EARS

Popping_____	Ringling_____	Pain_____
Fluid/congestion_____	Ear infections_____	Teeth Grinding_____
Decreased hearing_____	Ear Pain_____	Other_____
Sounds too loud_____	Excessive ear wax_____	

NOSE

Burning_____	Change in smell_____	Pain_____
Rubbing nose_____	Sinus Infections_____	Post nasal drip_____
Nasal discharge_____	Polyps_____	Congestion_____
Sneezing_____	Nosebleeds_____	Other_____

THROAT

Throat closes_____	Hoarseness_____	Laryngitis_____
Lose voice_____	Sore throat_____	Difficulty swallowing_____
Dry throat_____	Frequent clearing throat_____	Excessive Drooling_____
Salivation_____	Other_____	

THYROID

History thyroid problems or Goiter_____	Family history thyroid disease_____	Temperature change intolerance_____
History thyroid medication_____	History of neck radiation or x-ray treatment_____	Other_____

16. Review of systems (continued)

BREAST

Cysts _____ Drainage _____ Pain _____ Swelling _____

LYMPH GLANDS

Swelling _____ Soreness _____ Other _____

RESPIRATORY

Cough _____ Chest congestion _____ Chest tightness _____
Bronchitis _____ Wheezing _____ Frequent colds _____
Shortness of breath w/exercise _____ Asthma _____
Shortness of breath w/o exercise _____ Other _____

CARDIOVASCULAR

Chest pain/pressure _____ Hot flashes _____
Pain in left arm _____ Cold extremities _____ Spontaneous bruising _____
Arrhythmia (skipped beats) _____ Chilly feeling _____ Generalized swelling _____
Palpitations _____ Rapid heart rate _____ Puffy face _____
Sweating _____ Swelling of extremities _____
Heart murmur _____ High blood pressure _____
Low blood pressure _____ Other _____

GASTROINTESTINAL

Dry mouth _____ Poor appetite _____ Ileitis _____
Canker sores _____ Food craving _____ Colitis _____
Bad Breath _____ Compulsive overeating _____ Irritable bowel
Cold sores _____ Picky eater _____ syndrome _____
Bad taste in mouth _____ Bloating sensation _____ Rectal itching _____
Coated tongue _____ Visible abdominal distention _____ Rectal burning _____
Burning or stinging tongue _____ Frequent stomach rumbling _____ Rectal cramps _____
Heartburn _____ Abdominal pain _____ Hemorrhoids _____
Nausea _____ Vomiting _____ Infantile colic _____
Indigestion _____ Cramps _____ Other _____
Hiccups/burping _____ Diarrhea _____
Uncontrollable hunger _____ Constipation _____

GENITOURINARY

Frequent urination _____ Nervous bladder _____ Painful intercourse _____
Urgent urination _____ Lack of bladder control _____ Low libido _____
Urinary hesitancy _____ Frequent bladder infections _____ History of bedwetting _____
Urinary burning _____ Kidney infection _____ Other _____
Painful urination _____ Kidney disorder _____

16. Review of Systems (continued)

NEUROPSYCHIATRIC

Headaches_____	Excessive response to minor	Poor comprehension_____
Migraines_____	emotional stress_____	Confusion_____
Dizziness_____	Fear or panic attacks_____	Poor attention span_____
Fainting_____	Misunderstood by others_____	Staggered gait_____
Blackouts_____	Withdrawn_____	Appearing/feeling drunk_____
Insomnia_____	Negative_____	Stammering_____
Difficulty falling asleep_____	Paranoid_____	Eyes crossed or cross_____
Difficulty staying asleep_____	Feeling of hostility_____	Eyes track poorly_____
Awakened by frightening dreams_____	Feel insecure_____	Floating sensation_____
Difficulty staying awake_____	Often unhappy_____	Head "fog"_____
Lack of energy_____	Angry and/or aggressive	Symptoms of mental
Irritability_____	behavior_____	retardation_____
Anxious/nervous_____	Unprovoked anger_____	Learning disabilities_____
Hyperactive_____	Feelings of rage_____	Convulsions/seizures_____
Am a workaholic_____	Feeling apart/separate	Hallucinations_____
Jittery_____	from others_____	Restless legs_____
Depression_____	Feeling that surroundings are unreal_____	
Paralysis_____	Poor memory_____	Autism_____
Suicidal thoughts_____	Lack of concentration_____	Head rocking_____
Crying spells_____	Apathy_____	Numbness/tingling_____
Mood swings_____	Other_____	

FOR WOMEN

Vaginal itching_____	Pregnancy_____	Miscarriages_____
Vaginal discharge_____	Use of birth control_____	Date of last Pap Smear_____
Vaginal pain_____	Date of last menstrual	Age of first menstrual
	period_____	period_____
Recurrent vaginal yeast infections_____		Endometriosis_____
Premenstrual symptoms_____	Irregular periods_____	Other_____

FOR MEN

Pain in penis_____	Pain in testicles_____	Prostate enlargement_____
Other_____		

17. Do you adhere to a specific diet? Regular _____ Low salt _____
 Gluten-free _____ Diabetic _____ Religious restricted _____
 Rotation _____ Hypoglycemic _____ Vegetarian _____
 Low carb (Atkins) _____ Other _____
 Do you have symptoms before or after eating? _____

18. Please check any of the following that you have experienced:
 Eating binges _____ Relief of symptoms after fasting _____
 Foods you dislike or hate (specify) _____
 Foods you crave (specify) _____

 Regular use of coffee/ chocolate _____

19. What is your usual weight? _____ Do you have difficulty maintaining weight? _____

20. Do you use alcohol? YES _____ NO _____

If yes, please check any positive answers:

Alcoholic beverages relieve your symptoms _____

Even a small amount of alcohol affects you _____

You experience a hangover after a single drink _____

Symptoms appear a short time after you drink _____

You need to drink an alcoholic beverage at least once each day _____

You drink the same type of alcoholic beverage consistently. If yes, which type _____

Do you crave alcoholic beverages? _____ If yes, type _____

21. Do you smoke? YES _____ NO _____ Have you smoked in the past? YES _____ NO _____

22. Please check drugs below that you have used:

Frequent antibiotics _____ Frequent antacids _____ Amphetamines _____

Frequent pain relievers _____ Frequent "sleep aids" _____ Barbiturates _____

Frequent antihistamines _____ Frequent laxatives _____ Cocaine _____

Frequent nose drops or sprays _____ Frequent supplements _____ LSD _____

Frequent cough medications _____ Marijuana _____ Other _____

23. Please check if you have significant exposures to any of the following :

Dampness problem _____

Dog(s), Cat(s), other animals _____

Dust _____

Gas appliances Heat _____ Stove _____ Dryer _____ Fireplace _____

Gasoline or exhaust _____

Other chemical odors _____

Paint and Solvents _____

Pesticides/Herbicides _____

Potted Plants _____

Smog _____

Tobacco Smoke _____

24. Type of dwelling: House _____ Apt. _____ Other _____ Own _____ Rent _____

Is your residence in the open sunshine _____, Completely shaded _____ Partly shaded _____

Surrounded with trees _____

Is your residence more dry or damp? _____

Are you uncomfortable in a particular room of your residence? YES _____ NO _____

If yes, specify _____

Has your residence recently been fumigated or sprayed for insects/termites? YES _____ NO _____

Has your residence been tested for molds? YES _____ NO _____

25. Are there any farms, factories or refineries nearby? YES ___ NO ___

If yes, which type _____

26. Your occupation?: _____

Does anyone of your family have an occupation that brings in or generates chemical odors into the home? YES ___ NO ___ Have you ever felt ill from a job related exposure? YES ___ NO ___

Does your job expose you to chemicals or other irritants (glues, paints, or chemicals, models, chemistry or photography equipment, etc.)? YES ___ NO ___ If yes, describe _____

27. Please check responses you usually have after an exposure to the following:

No Reaction Like or Feel Good Dislike Feel Sick

Air Freshener				
Beauty parlor				
Clorox, Ajax, Comet				
Cosmetics				
Deodorant				
Disinfectant				
Dry cleaning stores				
Dry goods or textile stores				
Fires/fireplace				
Florist				
Fresh paint/paint thinner				
Freshly printed material (Xerox, papers, magazines)				
Freshly tarred road/blacktop				
Furniture polish/floor wax				
Gasoline, kerosene, fuel oil				
Hair spray				
Insect sprays/exterminator				
Glues				
Natural gas (oven, range, heat)				
New car interior				
New rubber				
New plastics				
Oven cleaner				
Permanent markers				
Photographic chemicals				
Strong household detergents				
Swimming pool				
Tobacco smoke				

28. Type of automobile and year _____

Do you notice a problem with odors in the car? YES _____ NO _____

29. Do you have central heat or air conditioning in your house? YES _____ NO _____

Do you have central heat or air filtration in your home? YES _____ NO _____

30. Your surroundings in your home are made of:

Mattresses: Plastic _____ cotton _____ covered _____

Pillows/Bedding: Cotton _____ Synthetic _____ Other _____

Flooring: Tile _____ Hardwood _____ Carpeting _____ Other _____

31. Please list all **Family medical history**, significant illnesses, including psychiatric.

MOTHER AGE _____
FATHER AGE _____

SIBLINGS:

Name _____ Age ____

Name _____ Age ____

Name _____ Age ____

Name _____ Age ____

CHILDREN:

Name _____ Age ____

Name _____ Age ____

Name _____ Age ____

Name _____ Age ____

OTHER FAMILY MEMBERS:

THIS COMPLETES THE END OF YOUR HISTORY. PLEASE SEND THIS FORM AND THE PRIVACY/FINANCIAL POLICY FORM TO THE WELLNESS RESOURCE MEDICAL CLINIC 2 WEEKS PRIOR TO YOUR FIRST VISIT.

EMAIL:

NEWPATIENTS@WELLNESSRESOURCEALLERGY.COM

MAIL:

**THE WELLNESS RESOURCE MEDICAL CLINIC
30111 NIGUEL ROAD SUITE K
LAGUNA NIGUEL, CALIFORNIA 92677**

FOR CHILDREN ONLY – CHECK THOSE THAT APPLY TO YOUR CHILD

1. Problems making and keeping friends _____
2. Wants to run things, or boss his peers or siblings _____
3. Sucks or chews (Thumbs, clothing, blanket) _____
4. Cries easily or often _____
5. Day Dreams _____
6. Fearful (of new situations, new people or places, going to school) _____
7. Is destructive _____
8. Is shy _____
9. Speaks differently from others the same age (baby talk, hard to understand, stuttering) _____
10. Is quarrelsome _____
11. Steals _____
12. Worries more than others (about being alone, illness, death) _____
13. Feelings easily hurt _____
14. Unable to stop repetitive activity _____
15. Childish or immature (wants help he shouldn't need, clings, needs constant reassurance) _____
16. Doesn't like or doesn't follow rules or restrictions _____
17. Is easily frustrated in efforts _____
18. Doesn't get along with brothers or sisters _____
19. Boasts or brags _____
20. Sassy to grownups _____
21. Picks at things (nails, nose) _____
22. Excitable, impulsive _____
23. Has a chip on his shoulder _____
24. Restless (squirmy) _____
25. Restless, always on the go _____
26. Tells lies or stories that are not true _____
27. Gets into more trouble than others the same age _____
28. Denies mistakes or blames others _____
29. Pouts and sulks _____
30. Disobedient or obeys resentfully _____
31. Fails to finish things _____
32. Bullies others _____
33. Is cruel _____
34. Is easily distractable _____
35. Fights constantly _____
36. Disturbs other children _____
37. Is basically an unhappy child _____
38. Lets self be pushed around _____