Carolyn DeSalvo, MD
346 North Sequim Avenue • Sequim, WA 98382
360.504 3243 • www.rainshadowintegrativemedicine.com
dr.carolyn@rainshadowintegrativemedicine.com

# Confidential Patient Health History and Questionnaire

Thank you for choosing ourservices to assist you in your pursuit of health and wellness.

Today's Date: _____________

Name: ________________________________________ Date of Birth: ____________________

Are there any issues you would like to discuss today?

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

What are your expectations regarding your initial visit? What are you hoping to get out of this visit?

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Next, I would like you to begin to give me your story. I am going to ask you to answer questions about your past, present and future. I believe the story of every life is sacred, rich, and fascinating. Your responses to the questions will help me to come to know the "whole" you. The questionnaire is a bit long, but when we meet we will review every bit of it. Feel free to skip any questions you do not wish to answer and if there are questions you prefer not to answer in writing but you would like to discuss in person, this is fine also.

## PAST - Tell me about where you have been:

Where were you born?_________________________________________________________________
Where did you spend your childhood?_______________________________________________________
Did you move a lot?_________________________________________________________________
Did you like school?_________________________________________________________________

Was learning a challenge?____________________________________________________
Are you presently a student?__________________________________________________
How many years have you spent in school?______________________________________
Do you have any degrees?___________________________________________________
Would you describe yourself as a lifelong learner?_______________________________

Any eating issues or disorders?_________________________________________________________

Describe a few childhood memories that you consider significant (happy, treasured, traumatic, important…)

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Tell me about your family:

What is your ethnic background? This information is helpful because people of similar geographic ancestry share certain biological characteristics that may put them at increased risk of certain diseases.

____Asian/Pacific Islander ____Black ____Hispanic ____Native American

____White Other:____________________

Do you have a family history of any of the following? (☐Check here if adopted, no family history).

| | Relationship (blood relative) | Myself |
|---|---|---|
| Alcoholism/Addiction | ☐ | ☐ |
| Anesthesia Problems | ☐ | ☐ |
| Anxiety | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Birth Defects | ☐ | ☐ |
| Bleeding Disorders | ☐ | ☐ |
| Cancer: Breast | ☐ | ☐ |
| Cancer: Colon | ☐ | ☐ |
| Cancer: Ovarian | ☐ | ☐ |
| Depression, Bipolar, etc | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Gerd | ☐ | ☐ |
| Heart Disease | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ |
| Broken Hip | ☐ | ☐ |
| Thyroid Problems | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Other | ☐ | ☐ |
| | | |
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Please list your parents' and siblings' current ages, whether they are alive or deceased, and any major illnesses they have or had. (☐ Check here if adopted. If you are adopted, please complete the following information regarding your adoptive family. The information will not be reviewed from a genetic standpoint, but is still an important part of this story about you!)

| | Alive/Deceased? (Circle) | Current Age or Age at Death | Illnesses |
|---|---|---|---|
| Mother | Alive Deceased | | |
| Father | Alive Deceased | | |
| Siblings | Alive Deceased | | |
| | | | |
| | | | |

Tell me about your own medical history: Have you had to deal with any of the following medical issues?

ALLERGIES: include food and environmental allergies

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |

SURGERIES: list all operations giving year, city and procedure

| Year | City | Procedure |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

HOSPITALIZATIONS: list any hospitalizations unrelated to surgery (such pneumonia, broken bones, etc)

| Year | City | Procedure |
|---|---|---|
| | | |
| | | |
| | | |
| | | |



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Is there any special testing you have had that you wish me to know about, such as EKG, MRI, genetic testing, etc?
SPECIAL TESTS:

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

Early detection of diseases can impact our long-term well-being. What preventive tests have you had?

____Pap smear: generally after age 21, unless otherwise needed. Approximate date________

____HPV vaccine: recommended between ages 9 and 26. ____Yes ____No _____N/A

____Mammogram: generally after age 40, unless otherwise needed. Approximate date________

____Colonoscopy: generally after age 50, unless otherwise needed. Approximate date________

____Bloodwork: do you have a copy of your most recent bloodwork?___ Approximate date________

For the most up-to-date information on vaccines and immunizations, please visit [www.cdc.gov/vaccines/](http://www.cdc.gov/vaccines/)

Who do you look to as your health advisors?

____Primary Care Physician ____Physical Therapist ____Minister

____Cardiologist ____Psychotherapist ____Rabbi

____Chiropractor ____Counselor ____Priest

____Naturopath ____Other___________ ____Other______________

Whew! This is a lot! Take a break if you need to!



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## PRESENT - Tell me about where you are now:

Let's start with how youhave been feeling the last few months. If it is longer or shorter, feel free to make a note.

Review of Systems

Do you have any of the follow symptoms or problems? Pleaseheck all that apply to you.

| General | |
|---|---|
| Fatigue | ☐ |
| Difficulty sleeping | ☐ |
| Nightmares, recurrent dreams | ☐ |
| Fevers | ☐ |
| **Eyes** | |
| Blurry vision | ☐ |
| Eye pain | ☐ |
| **Ears/Nose/Throat/Sinuses** | |
| Hearing loss | ☐ |
| Ringing in ears | ☐ |
| Frequent infections | ☐ |
| Pain | ☐ |
| Frequent canker sores | ☐ |
| **Heart/Circulation** | |
| Palpitations or irregular pulse | ☐ |
| Chest discomfort (tightness, pressure, pain) | ☐ |
| Leg swelling | ☐ |
| Varicose veins | ☐ |
| Lungs | ☐ |
| Shortness of breath | ☐ |
| Wheezing | ☐ |
| Other: | ☐ |
| **Digestion/Elimination** | |
| Heartburn | ☐ |
| Nausea/vomiting | ☐ |
| Abdominal pain/cramps | ☐ |
| Abdominal bloating | ☐ |
| Excessive belching | ☐ |
| Excessive flatus | ☐ |
| Constipation | ☐ |
| Diarrhea | ☐ |
| Black stools | ☐ |

| Muscles/Bones/Joints | |
|---|---|
| Muscle pain | ☐ |
| Muscle cramps or spasms | ☐ |
| Tendonitis | ☐ |
| Joint pain/stiffness/swelling | ☐ |
| Low back pain | ☐ |
| Other: | ☐ |
| **Nervous System** | |
| Headaches | ☐ |
| Migraines | ☐ |
| Dizziness | ☐ |
| Balance problems | ☐ |
| Seizures | ☐ |
| Weakness/numbness/tingling sensations | ☐ |
| Memory problems | ☐ |
| Concentration problems | ☐ |
| **Immune Systems** | |
| Lymph nodes | ☐ |
| **Hormonal/Endocrine** | |
| Excessive thirst | ☐ |
| Excessive hunger | ☐ |
| Cold or heat intolerance | ☐ |
| **Blood** | |
| Easy bruising | ☐ |
| Abnormal bleeding | ☐ |
| **Skin** | |
| Rashes | ☐ |
| Eczema | ☐ |
| Change in appearance of any moles | ☐ |
| Other: | ☐ |
| **Psychiatric/Psychological (circle all that apply)** | |
| Anxiety or nervousness | |
| Fears, phobias, panic attacks | |
| Sadness, grief, depression | |
| Angry, irritable, impatient, critical | |
| Suicidal thoughts | |



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## Reproductive Information

Age at first menses_____

Have you had a hysterectomy?_____ Are you menopausal?_____

First day of last period_____ Number of days between periods_____

Are your periods regular?_____ Irregular?_____

How many days does the flow last?_____

Is the flow heavy?_____ Tolerable?_____ Moderate?_____ Excessive?_____ Clotty?_____

Do you have cramps with your period?_____ Is cramping a problem for you?_____

Do you take medication to treat cramps?_____

Do you have pain or bleeding between periods?_____

D you have pain or bleeding during or after intercourse?_____

Date of last pap smear_________

Have you ever had an abnormal pap smear?_____

Have you received treatment for an abnormal pap smear?_____

Laser_____ LEEP_____ Freezing _____ Other _____

Sexual preference: ___________________________________________________________________

## Sexuality and Intimacy

Are you sexually active at this time?__________________________________________________________

Are you satisfied with your sexual relations at this time?_________________________________________

Are you having any concerns at this time?______

Please describe your concerns______________________________________________________________

______________________________________________________________________________________

Have you ever been sexually abused or assaulted?_______________________________________________

Do you feel safe in your present situation?____________________________________________________

Do you desire to have children in the future? _________________________________________________

What is your current method of contraception? _________________________________________________

Any problems or concerns with your current method? __________________________________________

Have you had any of the following sexually transmitted infections?

herpes____ chlamydia____ GC____ HPV____ syphilis____ HIV____ none____

Has your partner had any sexually transmitted infections?

herpes____ chlamydia____ GC____ HPV____ syphilis____ HIV____ none____

Have you ever been told you have any of the following conditions?

ovarian cysts____ uterine fibroids____ pelvic adhesions____

endometriosis____ PID/pelvic infection____

## Pregnancy Information

How many pregnancies?____

How many living children?____

Please indicate any complications with your pregnancies:

toxemia____ diabetes____ surgery____ infertility____ other_________________



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## ***Gynecologic Review of Systems*** *– check all that apply to you.*

| Menstrual | |
|---|---|
| PMS - tolerable | ☐ |
| PMS - excessive | ☐ |
| | ☐ |
| **Vaginal** | |
| discharge | ☐ |
| odor | ☐ |
| itching | ☐ |
| burning | ☐ |
| recurrent infection | ☐ |
| | ☐ |
| **Hair Growth** | |
| face | ☐ |
| breasts | ☐ |
| other: | ☐ |
| | ☐ |
| **Breasts** | |
| do you check your breasts? Yes___ No ___ | |
| nipple discharge | ☐ |
| lumps | ☐ |
| pain | ☐ |
| rash | ☐ |
| biopsy | ☐ |
| other: | ☐ |
| | ☐ |

| Sleep | |
|---|---|
| trouble falling asleep | ☐ |
| trouble awakening | ☐ |
| do not feel rested in morning | ☐ |
| mind is "on" and I can't turn it off | ☐ |
| needing to urinate awakens me a lot | ☐ |
| sleep apnea | ☐ |
| **Menopause** | |
| hot flashes | ☐ |
| night sweats | ☐ |
| moody | ☐ |
| tearful | ☐ |
| vaginal dryness | ☐ |
| other: | ☐ |
| | ☐ |
| **Urinary** | |
| frequency greater than 6 times in 24 hrs | ☐ |
| urgency, rushing | ☐ |
| blood in urine | ☐ |
| need to wear pads daily | ☐ |
| | ☐ |
| **Pelvic** | |
| pressure | ☐ |
| feels like something is falling out | ☐ |
| other: | ☐ |

<u>Medications/vitamins/supplements</u>

What are your thoughts concerning the use of supplements?

______I love them

______I don't like them

______They are a racket

______I take them for a while and then I get out of the habit of taking them

______I buy them but I forget to take them



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SUPPLEMENTS:

List all vitamins, mineral, herbs and other nutritional supplements you are taking. When possible, indicate the mg or IU's and the form (e.g. calcium carbonate vs. calcium lactate). You may bring a photocopy of container labels.

| Supplement | When Started | Daily Dosage | Supplement | When Started | Daily Dosage |
|---|---|---|---|---|---|
| | | | | | |
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MEDICATIONS:

List all medications you take. Include prescription medications and over-the-counter medications.

| Medicine | When Started | Daily Dosage | Medicine | When Started | Daily Dosage |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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Do you take antibiotics for dental procedures? Yes _____ No ______

Do you have devices or implants that require antibiotics? Yes ______ No ______



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Lifestyle Please answer the following questions regarding your daily activities. Our habits and attitudes affect our bodies' innate healing abilities.

Dietary: What foods do you eat on a regular basis?

| | |
|---|---|
| Breakfast | |
| Lunch | |
| Dinner | |
| Cravings | |
| Dislikes | |
| Snacks | |
| Comfort food | |
| Food allergies | |
| Fluid sources | |
| Sweeteners | |

How many of your meals each week (including breakfast and lunch) are prepared in a restaurant?_____
Would you like to discuss your eating habits and diet? Yes _____ No _____
Is weight an issue for you? Yes _____ No ______ Do you wish to discuss this? Yes _____ No _____

Habits:

| |
|---|
| Alcohol<br>☐ Never used<br>☐ Estimate drinks per day__________ or week___________ or month_________<br>☐ Alcohol problem from age ______ to ______ |
| Cigarettes<br>☐ Never used<br>☐ Smoked from age _____ to _____, _____ packs per day.<br>☐ Other ____________________________________________ |
| Use of other recreational drugs? |
| Coffee, cola or other caffeinated drinks?_____ How many 8 ounce servings per day?_____ |
| Safety issues: please circle any issues you wish or discuss or receive information regarding<br>sunscreen seatbelts helmets smoke detectors carbon monoxide detectors<br>safe storage of guns earthquake plan fire extinguishers |

Name your top three challenges or stressors:

| |
|---|
| 1. |
| 2. |
| 3. |

Name your top three joys or comforts:

| |
|---|
| 1. |
| 2. |
| 3. |



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Wellness Practices:

What exercise do you do in a typical week? Try to aim for stretching, aerobic activity and weights.

| Exercise | Times per Week | Minutes per Time |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Would you like to discuss your exercise regimen? Yes _____ No _____

What mind-body practice do you have (e.g. meditation, yoga, prayer)?

How often do you do this practice?

What wellness therapies do you receive on a routine basis?

___Acupuncture ___Massage
___Chiropractic ___Psychotherapy
___Energy work ___Other

What are your leisure activities/hobbies?

Spirituality – I define spirituality as connection. Circle where you feel most connected:

Self Family Friends Co-workers Groups Nature Animals Universe Creator

Other: ______________________________________________________________________________

What brings meaning or purpose to your life?

Relationships:

With whom do you live? (include roommates, friends, partner, spouse, children, parents, relatives)

Do you have any pets?

Do you feel safe in your home?

Do you have any relationships in which you feel threatened or concerned for your safety?

What are the ages of your children?

Who are the most important people in your life?



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Occupation:

| If you are a student, what are your current studies? |
|---|
| What is your current or previous work? |
| Are you satisfied with your work? |
| Does your work impact your well-being? (difficult co-worker or boss, toxic exposure to chemicals, dust, etc.) |

## FUTURE - Tell me about where you want to be…

- ☐ I am happy where I am and I have the resources (family, friends, emotional...) to draw on should difficult times come upon me.
- ☐ No desire or need for change.
- ☐ I would consider changing ______________________________________________________________.
- ☐ I am thinking about changing ___________________________________________________________.
- ☐ I am making plans to change ____________________________________________________________.

What other information about you do you want me to know?

| |
|---|
| |

"The natural healing force within each of us is the greatest force in getting well." -Hippocrates

Would you like a copy of this health history and questionnaire for your records? Yes____ No ____



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