

MEDICAL HISTORY QUESTIONNAIRE

Please, mail in or fax to: 212-582-1737

DATE OF FIRST APPOINTMENT:

___/___/___

How did you hear from us?

Please answer here

Please note: Many tests you will have at your first visit are based on the evaluation of this questionnaire.

It is important that we receive it **five days before** your **appointment unless otherwise discussed with our New Patient Department.**

NAME: _____ LAST FIRST	ADDRESS: _____ _____ CITY ZIP COUNTRY
WEIGHT: _____ NOW: IDEAL:	PHONE: () _____
YOUR E-MAIL (will remain confidential): _____	

Health Maintenance Information:

In order to provide us with a better understanding of your health needs, please answer all of the questions as accurately as possible. Approximately when did you last have the following:

Physical Exam	date:	Eye Exam	date
Electrocardiogram (EKG)	date	Gyn	date
Echocardiogram	date	Mammogram	date
Stress Test	date	Prostate/ Rectal	date
Chest X-RAY	date	Colonoscopy	date
Dental	date		

It is imperative that you send or bring any lab work done within 6 weeks of your appointment or Dr. Salerno will repeat them. Also, send or bring written reports of the most recent tests (X-rays, ekg...) that you have done in the year prior to your appointment.

Have you ever been diagnosed with the following (circle your answer):

Diabetes yes / no Cancer yes/ no
Heart disease yes/ no Hypertension yes / no Heavy Metal toxicity yes/ no

Please, list ALL the medical reasons, symptoms and goals for which you are seen by Dr. Salerno:

FOOD DIARY

Patient Name: _____ Today's date: _____

Please complete the following sections and return with your *Health Indicator, Medical History Questionnaire* and *Demographic information Sheet*

TYPICAL DAY'S DIET

<i>Prior to starting Atkins Diet</i>		<i>Currently on a Atkins Diet</i>	
Typical Day's Diet	Typical Snacks	Typical Day's Diet	Typical Snacks
Breakfast		Breakfast	
Lunch		Lunch	
Dinner		Dinner	

PLEASE, estimate the frequency with which you eat the following>

0> never or zero *R.*> rarely or less than once a week *M*> moderate amount(1-5 per week)

D> one serving daily *2 D*> two servings daily *3 D*> three servings or more

<i>Eggs</i>	<i>Caffeinated coffee</i>	<i>Grains (rice, barley, oats...)</i>
<i>Eggwhites only</i>	<i>Regular tea</i>	<i>Fruits</i>
<i>Fish</i>	<i>Herbal tea</i>	<i>Fruit juice</i>
<i>Shellfish</i>	<i>Bread/rolls...</i>	<i>Cake, cookies, candy</i>
<i>Poultry</i>	<i>Pasta</i>	<i>Sugar</i>
<i>Red meat</i>	<i>Salads</i>	<i>Honey/ maple syrup...</i>
<i>Cheese</i>	<i>Beans/ legumes</i>	<i>Regular sweetened soda</i>
<i>Milk</i>	<i>Starchy vogs: potatoes, carrots, beets...</i>	<i>Diet soda</i>
<i>Yogurt</i>	<i>Non- starchy vogs: Broccoli, zucchini green beans...</i>	<i>Diet iced tea</i>
<i>Water</i>		<i>Aspertame, equal, nutrasweet...</i>

CONTINUED >>>>>>>>

FOOD DIARY CONTINUED

Do you follow a specific dietary regimen? if yes, please describe:

Do you follow a specific exercise regimen ? If yes, describe:

Do you follow a low fat Diet? A low cholesterol diet? Do you miss meals?

What are your favorite foods?

Do you get cravings ?

Sugar cravings ?

Describe:

PLEASE: name ALL supplements you take or bring a TYPED list>>>

Additional comments:

HEALTH

INDICATOR TEST

INSTRUCTIONS

Check off each symptom that you have according to its severity:

- 0> means you never have the symptom
- 1> means it is mild when it occurs or it occurs occasionally
- 2> means moderate or occurring at least once a week
- 3> means severe or occurring frequently

MULTIPLY the number of checks in EACH column by the number at the top of the column and then add the number in the three columns to get YOUR TOTAL SCORE

Your total score

DATE : _____

0	1	2	3	
				<i>Tired all the time</i>
				<i>Hungry between meals or at night</i>
				<i>Depressed</i>
				<i>Insomnia</i>
				<i>Wake up after a few hours sleep</i>
				<i>Fearful- overwhelmed by people, places or things</i>
				<i>Can't decide easily</i>
				<i>Can't concentrate</i>
				<i>Poor memory</i>
				<i>Worry frequently</i>
				<i>Feel insecure or low self image</i>
				<i>Highly emotional</i>
				<i>Moody</i>
				<i>Cry easily or feel like crying inside</i>
				<i>Fits of anger</i>
				<i>Magnify insignificant details</i>
				<i>Eat candy, cake, cookies, or drink soda pop</i>
				<i>Eat bread, pasta, potatoes, rice or beans</i>
				<i>Consume alcohol</i>
				<i>Drink more than 3 cups of coffee between meals or mid-afternoons</i>
				<i>Can't work well under pressure</i>
				<i>Headaches</i>
				<i>Sleepy or drowsy after meals</i>
				<i>Lack of energy</i>
				<i>Reduce initiative</i>
				<i>Can't get started in the morning</i>
				<i>When nervous</i>
				<i>Stomach cramps or nervous stomach</i>
				<i>Allergies, asthmas, hay fever, skin rash, sinus trouble, ect</i>
				<i>Fatigue relieved by eating</i>
				<i>Suicidal thoughts or tendencies, feelings of hopelessness</i>
				<i>Bored</i>
				<i>Bad dreams</i>
				<i>Irritable before meals</i>
				<i>Heart beats fast, palpitations</i>
				<i>Get shaky inside if hungry</i>
				<i>Feel faint if meal is delayed</i>
				<i>Ulcers, gastritis, chronic indigestion, abdominal bloating >>>> continue NEXT before totaling score!</i>

Health indicator Test continued.

0	1	2	3	
				<i>Cold hands and feet</i>
				<i>Trembling, shaking, of the hands</i>
				<i>Blurred vision</i>
				<i>Dizziness, giddiness, or light headedness</i>
				<i>Aware of breathing heavily</i>
				<i>Bruise easily</i>
				<i>Reduced sex drive</i>
				<i>Incoordination- drop or bump into things</i>
				<i>Sweating excessively</i>
				<i>Unsocial or anti social behavior</i>
				<i>Muscle twitching or cramps</i>
				<i>Excessive thirst</i>
				<i>Phobias</i>
				<i>Weight change</i>
				<i>Frequent urination</i>
0				Total:

