

Center for Optimum Health, P.C.

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Dear Patient:

Please fill out this extensive questionnaire and bring it with you for your appointment on _____ at _____. It has been designed to provide a complete evaluation of your health and lifestyle. Please plan on taking up to one to two hours to properly fill in all the information. Some of the questions may deal with very personal information. You do not have to provide any information that you do not want to, however it is frequently the most sensitive areas of life that can be the most important with respect to health. Please be as candid as possible. These records are kept confidential from all sources including spouses and parents. Also note you may require some help on the questions that deal with early childhood. Please try to be as thorough as possible.

As some of our patients are chemically sensitive, we ask that you please not wear perfume, cologne, or scented hairspray at the time of your appointment. You may wish to bring socks or slippers to wear in the office. We request the courtesy of at least 48 hours cancellation notice prior to your visit or you may be charged for a missed appointment.

Name _____ Marital Status _____ Date ____ / ____ / ____

How did you hear of us? _____

Dates of last: Complete physical exam _____, Blood Test _____

Mammogram _____, Pap Test _____, Rectal Exam _____

List any other doctors you are currently consulting:

Name _____ Address _____ Phone _____

Height _____ Weight _____ Age _____ Last time you really felt well _____

Please list, in order of importance, the symptoms concerning you most.

Symptom _____ How long _____ How often _____ How severe _____

Past history- On the back side of this sheet, please list in chronological order any illnesses, hospitalizations, injuries, pregnancies, abortions, miscarriages, surgeries, dental fillings, root canals, immunizations, and other medical or diagnostic procedures such as x-rays or biopsies. Minor problems such as flus and colds are not a concern, but please try to be as complete as possible.

List any allergies or sensitivities to drugs, supplements, herbs, foods, pollen, animals, or chemicals.

List all medications you are currently taking. Include birth control pills and non-prescription drugs.

Name _____ Reason _____ How long _____ How often _____

Have you ever had a frequent or prolonged use of the following drugs? If so, how were you at the time and how long did you take them?

Antibiotics _____ Antihistamines _____

Cortisone, ACTH, Prednisone _____ Steroids _____

Please describe how you feel about your relationships, etc. Use an "S" for satisfying, "OK" if fine, and "P" if it might be a problem area.

Spouse _____ Children _____ Work _____ Sex life _____ Finances _____ Your life in general _____.

Briefly describe any problem area on the reverse side of this sheet.

Do you smoke or have you smoked? _____ How much? _____ How long? _____

Have you stopped? _____ If so, when? _____ Would you like to stop? _____

Alcohol intake (type, amount, frequency) _____

Have you ever had a problem with alcohol or drugs? _____

Do you have any Tattoos? _____ How many? _____ Locations _____

Do you have any Body Piercings? _____ How many? _____ Locations _____

Do you exercise regularly? _____ Type of exercise _____

How often _____ Length of sessions _____

Would you describe your stress level as low, moderate, or high? _____

Describe the kind of work you do? _____

Does your place of work have: Smoking _____, Toxic fumes _____, Fresh air _____, Florescent Lights _____,

New paint _____ New carpets _____, Window providing light _____, New Building _____,

Radiation _____, Chemicals _____, ?

Do you use a computer at your desk or work station? _____

Have you ever lived or worked around paints, pesticides, chemicals, radiation, mercury, lead, asbestos, or heavymetals? _____

Have you ever lived in a trailer? _____ When _____ How long? _____

Are there any personal problems or feelings that you don't feel quite comfortable discussing with your closest friends? _____ Would you like to discuss them with the doctor? _____

Please check if any of the following apply to you. Use 'P' if they applied in the past, 'C' if they are current, and 'I' if they are intermittent.

Headaches
 Neck pain
 Neck lumps/ swelling
 Loss of balance
 Dizzy spells/ vertigo
 Fainting/ lightheadedness
 Blurry vision/ double vision
 Cataracts
 Glaucoma
 Eye pain or itching
 Watery eyes
 Mental confusion/ cloudiness
 Hearing difficulties
 Earaches or drainage
 Noises or ringing in the ear
 Recurrent ear infections
 Dental problems/ decay
 Sore or bleeding gums
 Sore tongue
 Decreased sense of taste
 Sores in or around mouth
 Difficulty swallowing
 Herpes or cold sores
 Congested or runny nose
 Sneezing spells
 Frequent colds or infections
 Nasal polyps
 Sore throats
 Hoarse voice
 Hepatitis, pancreatitis
 Colitis or Crohn's disease
 Diverticulosis or diverticulitis
 Waking from sleep to urinate
 Frequent urination
 Involuntary loss of urine
 Burning on urination
 Brown, red, or cloudy urine
 Decreased force of urine stream
 Difficulty starting urination
 Continual urge to urinate
 Kidney stone
 Bladder or kidney infections
 Venereal disease
 Hernia
 Osteoporosis
 Pain in muscles or joints
 Arthritis/ Bursitis
 Back or shoulder pain
 Weakness
 Painful feet
 Leg cramps
 Trembling or tremors
 Seizures or epilepsy

Anemia
 Hair loss
 Numbness or tingling
 Acne
 Skin tumors
 Sinusitis
 Shortness of breath
 Wheezing or asthma
 Cough
 Cough up blood
 Chest colds/ pneumonia
 Heart murmur
 High blood pressure
 Rapid or skipped heartbeat
 Chest pain, chest pressure
 Swollen feet or ankles
 Varicose or spider veins
 Difficulty breathing at night
 Phlebitis/ embolism
 Stomach or duodenal ulcers
 Indigestion or heartburn
 Nausea or vomiting
 Intestinal gas
 Bloating
 Belching
 Flatulence
 Abdominal pain or cramps
 Constipation
 Diarrhea or loose stools
 Black stools
 Gray stools
 Jaundice
 Pain in rectum
 Rheumatic fever
 Stroke
 Blood in stools
 Dry skin, irritation, flaking
 Rash, excema, psoriasis
 Hives
 Scalp problems, dandruff
 Bruise easily
 Thyroid disturbance/ goiter
 Loss or gain in weight
 Itching or burning skin
 Feel warm
 Feel cold
 Loss of appetite
 Always hungry
 Armpit or groin swelling
 Fatigue or weariness
 Sleep difficulty
 Fever
 Chills

- Excessive sweating
- Inability to perspire
- Night Sweats
- Diabetes/ low blood sugar
- Lowered sex drive
- Nervousness/ anxiety
- Depression
- Received blood or plasma
- Cancer or tumors
- Elevated cholesterol

- Suicidal thoughts
- Hyperactivity
- Gout
- Gallstones
- Traveler's diarrhea/ turista
- Rectal itching
- Brittle fingernails
- Heart disease
- Neurological disease
- Reaction to immunization

How often do your bowels move? _____

For men only:

- Lump or swelling of testicle
- Difficulty with erection

- Drainage from penis
- Prostate problems

For women only:

- Irregular menstrual period
- Premenstrual symptoms
- Vaginal discharge
- Painful intercourse
- I.U.D.
- Discharge from nipples

- Spotting between periods
- Menstrual cramps
- Vaginal rash/ itching
- Pelvic infection
- Breast lumps or pain
- Hot flashes

Date of last menses _____ How many days between menstrual periods? _____

Have any of your immediate family (including grandparents) had:

- Alcohol or drug problems
- Thyroid problems
- Cancer
- Diabetes
- Tuberculosis
- Mental illness

- Anemia
- Gout
- Weight disorder
- Heart disease
- High blood pressure
- Osteoporosis

Family history (please list age or age at death, and any medical problems):

Father _____
 Mother _____
 Grandmother _____
 Grandmother _____
 Grandfather _____
 Grandfather _____
 Brothers _____
 Sisters _____

Please estimate about how often you eat the following foods:

VERY FREQUENT = Once or more per day

OFTEN = 3 or 4 times per week

OCCASIONAL = Once per week

SELDOM = One or two times per month

NEVER = Essentially total avoidance

1. Fresh fruit _____
2. Fresh vegetables _____
3. Whole grains _____
4. Organic grains _____
5. Legumes (beans) _____
6. Butter _____

7. Eggs _____
8. Meats(poultry, fish) _____
9. Sugar, desserts _____
10. Pkgd./proc. Food _____
11. Chips _____
12. Frozen/can food _____

- 13. Coffee _____
- 14. Black tea _____
- 15. Alcohol _____
- 16. Restaurants _____
- 17. Fast food restaurants _____
- 18. Sodas _____
- 19. Fried foods _____

- 20. Mayo/margarine _____
- 21. Milk _____
- 22. Cheese _____
- 23. Salt _____
- 24. White flour product _____
- 25. Excessive eating _____

Specify what foods and drinks you normally take during a day:

Morning _____

Afternoon _____

Evening _____

Do you think you might have an eating disorder? _____

How often during the day do you eat something? _____

Do you completely chew your foods before swallowing? _____

What water do you drink? _____ Do you have a water purifier? _____

If so, what kind? _____

Do you use an: electric blanket _____, electric mattress pad _____, water bed _____, or microwave _____?

List history of foreign travel: U.S.A.

(East) _____ When? _____

(West) _____ When? _____

(South) _____ When? _____

(Central) _____ When? _____

Foreign _____ When? _____

_____ When? _____

_____ When? _____

_____ When? _____