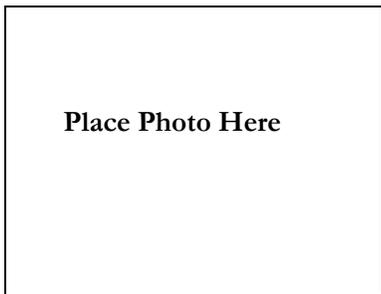




DR. KARA FITZGERALD, LLC FUNCTIONAL MEDICINE

27 glen road 4th floor sandy hook ct 06482 phone 203 304 9502 fax 203 304 9503
kf@drkarafitzgerald.com drkarafitzgerald.com

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.



First Name: _____ Middle Name: _____ Last Name: _____

Nickname _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____ - _____ Birth Date: ____/____/____ Age: _____
month day year

Cell Phone: (_____) _____ - _____

Place of Birth: _____

Occupation: _____ City or town & country if not US

Height: ____' ____" Weight: _____ Sex: _____

Today's Date _____ Email _____

Would you like to receive our eNewsletter? Yes____ No____

Referred by Physician/Clinician (name, contact) _____
 Book Website Media Friend or Family Member Other _____

Physician:
Name _____ *Phone Number* _____

Fax _____

Insurance Provider _____

Please list all food or drug allergies: _____

Please list what kind of reaction you have to these allergies: _____

What do you hope to achieve with your visit to Dr. Fitzgerald? _____

When was the last time you felt well? _____

What caused the change in your health? _____

What makes you feel worse? _____

What makes you feel better? _____

If you could erase three problems, what would they be? _____

1. Please check appropriate box(es):

- | | | | |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)

Example: Wendy, age 7, sister

4. Do you have any pets or farm animals? Yes ___ No ___ Types _____
 If yes, where do they live? 1. ___ indoors 2. ___ outdoors 3. ___ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes ___ No ___
 If so, when and where? _____

What city and state did you grow up in? _____ rural or industrial? _____

6. Have you or your family recently experienced any major life changes? Yes ___ No ___
 If yes, please comment: _____

7. Have you experienced any major losses in life? Yes ___ No ___
 If so, please comment: _____

8. How important is religion (or spirituality) for you and your family's life?

- a. ___ not at all important
- b. ___ somewhat important
- c. ___ extremely important

9. How much time have you lost from work or school in the past year?

- a. ___ 0-2 days
- b. ___ 3-14 days
- c. ___ > 15 days

10. Previous jobs: _____

11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction. Witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes. Please do your best to answer the following questions:

- a. Did you feel safe growing up?
yes no
- b. Have you been involved in abusive relationships in your life?
yes no
- c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
yes no
- d. Do you currently feel safe in your home?
yes no
- e. Do you feel safe, respected, and valued in your current relationship?
yes no
- f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
yes no
- g. Would you feel safer discussing any of these issues privately?
yes no

12. Past Medical and Surgical History:

ILLNESSES	WHEN	COMMENTS
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, convulsions, or seizures		
k. Gallstones		
l. Gout		
m. Heart attack/Angina		
n. Heart failure		
o. Hepatitis		
p. High blood fats (cholesterol, triglycerides)		

q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		
	INJURIES	WHEN	COMMENTS
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
	DIAGNOSTIC STUDIES	WHEN	COMMENTS
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Other (describe)		

	OPERATIONS	WHEN	COMMENTS
au.	Appendectomy		
av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		

13. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

FAMILY HISTORY

	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Children</u>
Ages (if living)	_____	_____	_____	_____	_____
Health	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____
<u>Check those applicable:</u>					
Anemia	-	-	-	-	-
Arthritis	-	-	-	-	-
Asthma/Hayfever/Hives	-	-	-	-	-
Cancer	-	-	-	-	-
Type of Cancer _____					
Diabetes	-	-	-	-	-
Glaucoma	-	-	-	-	-
Gout	-	-	-	-	-
Heart Disease	-	-	-	-	-
High Blood Pressure	-	-	-	-	-
Kidney Disease	-	-	-	-	-
Mental Illness	-	-	-	-	-
Seizures/Epilepsy	-	-	-	-	-
Stroke	-	-	-	-	-
Thyroid problems	-	-	-	-	-

14. How often have you have taken antibiotics?

< 5 times > 5 times

Infancy/ Childhood		
Teen		
Adulthood		

15. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

< 5 times > 5 times

Infancy/ Childhood		
Teen		
Adulthood		

16. What medications are you taking now? Include non-prescription drugs.

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

17. Are you allergic to any medications?

Yes____ No____

If yes, please list them and what kind of reaction you have to them:

18. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

19. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
d. Cesarean birth?				
2. As a child did you eat a lot of sugar and/or candy?				

20. As a child, were there any foods that you had to avoid because they gave you symptoms?

Yes____ No____

If yes, please: name the food and symptom (Example: milk – gas and diarrhea) _____

21. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

22. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

42. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
 a. If yes, which one(s)? ___lead ___cadmium
 ___arsenic ___mercury
 ___aluminum

43. Do odors affect you? Yes____ No____

44. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

45. Have you ever had psychotherapy or counseling? Yes____ No____
 Currently? _____ Previously? _____ If previously, from _____ to _____.
 What kind? _____
 Comments: _____

46. Are you currently, or have you ever been, married? Yes____ No____
 If so, when were you married? _____ Spouse's occupation _____
 When were you separated? _____ Never _____
 When were you divorced? _____ Never _____
 When were you remarried? _____ Never _____ Spouse's occupation _____
 Comments: _____

47. Hobbies and leisure activities: _____

48. Do you exercise regularly? Yes__ No____ If yes, can you work up a good sweat? Yes____ No____
 If no, how motivated are you to start? _____
 If so, how many times a week? When you exercise, how long is each session?
 1. _____ 1x 1. _____ ≤15 min
 2. _____ 2x 2. _____ 16-30 min
 3. _____ 3x 3. _____ 31-45 min
 4. _____ 4x or more 4. _____ > 45 min

49. What type of exercise is it?
_____ Jogging/walking _____ tennis
_____ basketball _____ water sports
_____ home aerobics _____ other _____

50. What is the average time per day spent on your cell phone? _____
a. Do you use a headset? Yes _____ No _____
If so, what type is it? _____

51. Any other family history we should know about? Yes _____ No _____
If so, please comment: _____

52. What is the attitude of those close to you about your illness?
_____ Supportive
_____ Non-supportive

FOR WOMEN ONLY (questions 53-):

53. Have you ever been pregnant? (If no, skip to question 53.) Yes _____ No _____
Number of miscarriages _____ Number of abortions _____ Number of preemies _____
Number of term births _____ Birth weight of largest baby _____ Smallest baby _____
Did you develop toxemia (high blood pressure)? Yes _____ No _____
Have you had other problems with pregnancy? Yes _____ No _____
If so, please comment: _____

54. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram _____
Pap Smear: _____ Normal _____ Abnormal
Mammogram: _____ Normal _____ Abnormal

55. Have you ever used birth control pills? Yes _____ No _____ If yes, when _____

56. Are you taking the pill now? Yes _____ No _____

57. Did taking the pill agree with you? Yes _____ No _____ Not applicable _____

58. Do you currently use contraception? Yes _____ No _____
If yes, what type of contraception do you use? _____

59. Are you in menopause? No _____ Yes _____ If yes, age at last period _____
Do you take: Estrogen? _____ Ogen? _____ Estrace? _____ Premarin? _____ Other (specify) _____
Progesterone? _____ Provera? _____ Other (specify) _____

60. How long have you been on hormone replacement therapy (if applicable)? _____

61. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?
Yes _____ No _____ Not applicable _____

62. Please check if these symptoms occur presently **or** have occurred in the past 6 months.

GENERAL:	Mild	Mod- erate	Severe
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	Mild	Mod- erate	Severe
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			

Light-headedness			
MOOD/NERVES, Cont'd:	Mild	Mod-erate	Severe
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
DIGESTION:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			

Farting			
DIGESTION, Cont'd:	Mild	Mod-erate	Severe
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
SKIN PROBLEMS:			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			
Eczema			

Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

SKIN, DRYNESS OF:	Mild	Mod- erate	Severe
Eyes			
Feet			
Any cracking?			
Any peeling?			

Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
LYMPH NODES:			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
NAILS:			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			
Toenails			
White spots/lines			

RESPIRATORY:	Mild	Mod- erate	Severe
Bad breath			
Bad odor in nose			
Cough - dry			
Cough - productive			
Hay fever : Spring			
Summer			
Fall			
Change of season			

Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

URINARY:	Mild	Mod- erate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
FEMALE REPRODUCTIVE:			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			

FEMALE REPRODUCTIVE, Cont'd:	Mild	Mod- erate	Severe
<u>Premenstrual:</u>			
Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
<u>Menstrual:</u>			
Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Medical Symptom/Toxicity Questionnaire

NAME: _____ DATE: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

POINT SCALE

- 0 = Never or almost never have the symptom
- 1 = Occasionally have it, effect is not severe
- 2 = Occasionally have, effect is severe
- 3 = Frequently have it, effect is not severe
- 4 = Frequently have it, effect is severe

DIGESTIVE TRACT

- ___ Nausea or vomiting
- ___ Diarrhea
- ___ Constipation
- ___ Bloating feeling
- ___ Belching, or passing gas
- ___ Heartburn
- ___ Intestinal/Stomach pain

Total _____

EARS

- ___ Itchy ears Total
- ___ Earaches, ear infections
- ___ Drainage from ear
- ___ Ringing in ears, hearing loss

Total _____

EMOTIONS

- ___ Mood swings
- ___ Anxiety, fear or nervousness
- ___ Anger, irritability, or aggressiveness
- ___ Depression

Total _____

ENERGY/ACTIVITY

- ___ Fatigue, sluggishness
- ___ Apathy, lethargy
- ___ Hyperactivity
- ___ Restlessness

Total _____

EYES

- ___ Watery or itchy eyes
- ___ Swollen, reddened or sticky eyelids
- ___ Bags or dark circles under eyes
- ___ Blurred or tunnel vision (does not include near-or far-sightedness)

Total _____

HEAD

- Headaches
- Faintness
- Dizziness
- Insomnia

Total _____

HEART

- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

Total _____

JOINTS/MUSCLES

- Pain or aches in joints
- Arthritis
- Stiffness or limitation of movement
- Pain or aches in muscles
- Feeling of weakness or tiredness

Total _____

LUNGS

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficult breathing

Total _____

MIND

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical coordination
- Difficulty in making decisions
- Stuttering or stammering
- Slurred speech
- Learning disabilities

Total _____

MOUTH/THROAT

- Chronic coughing
- Gagging, frequent need to clear throat
- Sore throat, hoarseness, loss of voice
- Swollen/discolored tongue, gum, lips
- Canker sores

Total _____

NOSE

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation

Total _____

SKIN

- Acne
- Hives, rashes, or dry skin
- Hair loss
- Flushing or hot flushes
- Excessive sweating

Total _____

WEIGHT

- Binge eating/drinking
- Craving certain foods
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

Total _____

OTHER

- Frequent illness
- Frequent or urgent urination
- Genital itch or discharge

Total _____

GRAND TOTAL _____

Key to Questionnaire

Add individual scores and total each group. Add each group scores and give a grand total.

- Optimal is less than 10-- Mild Toxicity: 10-50 -- Moderate Toxicity: 50-100 -- Severe Toxicity: over 100

TIME LINE of MEDICAL COMPLAINTS and MAJOR LIFE EVENTS

In this space, go back as far as you can remember- or even earlier if you have that information- and document any medical issues or major life events that may have impacted your health-both favorably or negatively.

Prenatal period:

Birth:

Early childhood:

Middle childhood:

Teens:

Young adulthood:

Adulthood: