The Office of Dr. Mischa Grieder, N.D.

at

San Francisco Preventive Medical Group

Medical History Form

Date:_____

DOB:_____

Patient Name:_____ Occupation:_____

PCP:_____ Referring Physician:_____

Allergies:

- Drugs _____
- Asthma: Hay Fever_____ Hives_____
- Environmental Allergies _____
- Other Allergies _____

Past Medical History:

Have you ever had any of the following diagnoses? If yes, please check the box.

❑ALS	❑Alzheimer's Disease	❑Anemia
❑Asthma	❑Autism	❑Baker's Cysts
❑Bell's Palsy	❑Bursitis (Where?_____)	❑Carpel Tunnel Synd.
❑PANDAS	❑ME/CFS	❑Encephalitis
❑Fibromyalgia	❑Iritis	❑Meningitis
❑Multiple Sclerosis	❑Polymyalgia Rheumatica	❑Prostatitis
❑Psoriasis/Eczema	❑Tendonitis	❑TMJ
❑ Heart Disease	❑ Tuberculosis	❑ Kidney Stones
❑ High Blood Pressure	❑ Positive TB Skin Test	❑ Cancer
❑ Rheumatic Fever	❑ Stomach Ulcer	❑ Stroke
❑ Heart Murmur	❑ Hepatitis	❑ Convulsions
❑ Enlarged Heart	❑ Gallstones	❑ Phlebitis
❑ Pneumonia	❑ Thyroid Trouble	❑ Bleeding Disorder
❑ Pleurisy	❑ Diabetes	❑ STI

❑ Other_____

Patient Name: Todays Date_____

_____ DOB_____

Surgeries (Please give approximate date)

❑ Tonsillectomy_____ ❑ Hysterectomy_____ ❑ Gallbladder_____

❑ Hernia Repair_____ ❑ Biopsy_____ ❑ Splenectomy_____

❑ Appendectomy_____ ❑ Ulcer Surgery_____ ❑ Joint Surgery_____

❑ Other _____

Other Hospitalizations or Accidents:

Date ***Reason***

_____ _____

_____ _____

_____ _____

_____ _____

Immunizations (Give approximate dates)

❑ Tetanus_____ ❑ Diphtheria_____ ❑ Polio_____ ❑ Childhood_____

❑Lyme_____ ❑Hepatitis_____ ❑Travel_____ ❑Military_____

❑ Other_____

Women's Health:

Are you currently, or think you may be pregnant?_____ date of last period_____

Pregnancies ____ Miscarriages ____ Live Births _____

Age Menstruation Began_____ Cycle Length_____ Duration _____

Irregular periods?_____ Spotting between?_____ Painful?_____

PMS?_____ Other_____

Family Medical History:

Father's Age _____ Health Problems or Cause of Death_____

Mother's Age _____ Health Problems or Cause of Death _____

Siblings _____ their health _____

Have any of your relatives had: (list who, ie: parent, grandparent, sibling, etc.)

❑ Diabetes_____ ❑ Tuberculosis_____ ❑ Cancer_____

❑ Allergies_____ ❑ Arthritis_____ ❑ Heart Disease_____

❑ Bleeding Disorder_____ ❑ High Blood Pressure_____

❑ Chronic Back Pain_____ ❑ Psoriasis_____

❑ Other conditions not listed_____

Patient Name: Todays Date_____

_____ DOB_____

Current Health

Do you currently have any of the following?

General

❑Fatigue
❑Fevers – high low
❑Flu-like symptoms
❑Loss of voice/hoarseness
❑Sore Throats
❑Skin Rash
❑Swollen Glands
❑Recurring Nosebleeds
❑Goiter
❑Loss of Appetite
❑Hair Loss
❑Night Sweats
❑Unexplained Chills
❑Recent Weight Change
❑Other:_____

Gastrointestinal & Urinary

❑Abdominal Pain
❑Frequent Indigestion
❑Trouble with Swallowing
❑Change in Bowel Habit
❑Constipation
❑Diarrhea
❑Bloody Bowel Movement
❑Diverticuloses
❑Irritable Bladder
❑Urinary Frequency
❑Urinary Retention
❑Frequent Urination at night
❑Blood in Urine
❑Slow Urinary Stream
❑Painful Urination
❑Liver Enlargement
❑Spleen Enlargement
❑Tenderness in Abdomen
❑Vomiting
❑Vomiting blood
❑Other:_____

Heart and Lung

❑Abnormal echocardiogram
❑Chest Pain/Tightness
❑EKG Abnormalities
❑Heart Attack
❑Heart Palpitations
❑Skipped Heartbeats
❑High Blood Pressure
❑Mitral Valve Prolapse
❑Swelling of Ankles or Feet
❑Shortness of Breath
❑Wheezing
❑Frequent Coughing
Dry or Productive
❑Coughing up Blood
❑Other:_____

Eye and Ear

❑Blind Spots
❑Blurred Vision
❑Conjunctivitis
❑Diminished Periph. Vision
❑Double Vision
Horizontal *or*
Vertical
❑Drooping eyelids
❑Flashing Lights
❑Lazy Eye
❑Light Sensitivity
❑Optic Atrophy
❑Pressure behind Eyes
❑Uveitis
❑Vision loss/blindness
❑Eye pain
❑Ringing in the Ears
❑Hearing loss/deafness
One ear *or*
Both ears
❑Other:_____

Musculoskeletal

❑Muscle Pain or Aches
❑Muscle Cramps
❑Stiff Muscles
❑Loss of Muscle Tone
❑Jaw Pain or Stiffness
❑Back Pain or Stiffness
❑Neck Pain
❑Joint Pain
❑Stiff Joints
❑Hand Pain and/or
❑Swelling
❑Elbow Pain and/or
❑Swelling
❑Shoulder Pain / Swelling
❑Hip(s) Pain / Swelling
❑Knee Pain / Swelling
❑Feet/Ankle Pain /
❑Swelling
❑Leg aches
❑Other:_____

Reproductive

❑Breasts:
Infections or discharge?
❑Loss of Libido (decreased sex drive/activity)
❑Pelvic Pain
❑Menstrual Irregularities - _____
❑Symptoms Worsen around Menstruation
❑Other:_____

Cont'd on following page…

Patient Name: Todays Date_____

_____ DOB_____

Neurological

❑Abnormal EEG
❑Anxiety Attacks
❑Burning Sensation:
External
Internal
❑Change in:
Smell
Taste
❑Confusion
❑Decreased Concentration
❑Dementia
❑Depression
❑Difficulty:
Chewing
Swallowing
❑Dizziness
❑Fainting
❑Fatigue
❑Hallucinations
❑Headache:
Mild
Severe
❑Migraine:
With Aura
❑Involuntary Jerking
❑Irritability
❑Memory Problems
❑Meningitis
❑Mood Swings
❑Motion Sickness
❑Muscle Twitching
Where?_____
❑Nightmares
❑Numbness
Where?_____
❑Obsessive/Compulsive Behavior
❑Panic Attacks
❑Paranoia
❑Partial Paralysis
Where?_____

Neurological, cont'd…

❑Personality Change
❑Poor balance/difficulty walking
❑Restless Legs
❑Seizures
Epileptic or
Non-Epileptic
❑Sleep Disturbances:
Falling Asleep
Waking Frequently
❑Suicidal
❑Tearfulness
❑Tingling
Where?_____
❑Tremors or Shaking
❑Weakness of Limbs
❑Unusual Clumsiness
❑Other:_____

Special Children's Questions

❑Decreased Interest in Playing?

❑Poor School Performance?

❑When did he/she start whimpering/whining?

Abnormal Lab Results

Date / Lab

❑Pos. Lyme Elisa
❑Pos. Lyme WB
IgG
IgM
❑Pos. Lyme PCR
❑Pos. Lyme Culture
❑Other positive Lyme Tests:
_____

_____

❑Pos. Babesia
❑Pos. Erlichia
❑Pos. Bartonella
❑Pos. Mycoplasma
❑Elevated Liver Enzymes
❑Eosinophilia
❑Elevated ANA
❑Elev. SED rate
❑Elev. Cholesterol
❑Elev. Anticardiolipin
❑Rheumatoid Factor
❑VDRL (Syphillis)
❑Low IgG Serum
❑Low IgG Subclasses (1, 2, 3, 4)
❑CD57
❑C4A
❑Methylation Panel

Patient Name: Todays Date_____

_____ DOB_____

Toxicity Questionnaire

Travel History:

If you have traveled outside of the U.S., please list destinations, and if applicable, any related illness here:

Place	Date	Travel related Illness?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Please use an additional sheet of paper if needed)

Mold Exposure:

❑In home? *If yes,* age of home_____ ❑Previous home? *If yes,* age of home_____
❑Workplace ❑School

Infection History:

Please indicate if you've had these infections, and if so, how many times.

❑ear infections_____ ❑strep_____ ❑pneumonia_____ ❑sinus_____
❑Frequent Antibiotic use? ❑Frequent use of Tylenol?

Dental:

❑Amalgams how many_____ ❑Root Canals_____ ❑implants_____
Any removed?_____ ❑infections_____

Medical:

❑Breast Implants ❑Other Implants
Silicone or Saline?
❑Blood Transfusion ❑Plasma ❑Brain Injury (acquired or traumatic)
❑CNS Injury ❑Seizure ❑Stroke
❑Chemotherapy ❑Radiation

Diet:

Aspartame Intake: ❑Artificial Sweeteners ❑Diet Tea ❑Diet Soda
High Fish Intake: ❑Tuna ❑Swordfish ❑Shark
Other Foods: ❑Wild Game ❑Mushrooms

Other:

Pesticide exposure: ❑in home ❑outside home ❑golf ❑farm
Hobbies: ❑Painting ❑Photo Development ❑Home Renovation
❑Firearms - Sanding off Paint?
Radiation: ❑Workplace ❑Cancer Treatment ❑Radon in Home
Electrical: ❑EMF ❑High Tension Wire ❑Workplace Computers
❑Transit Station
❑Well Water Consumption ❑Frequent Hot Springs

Patient Name: Todays Date_____

_____ DOB_____

Health Summary

Present Well Being:

Poor Below Average Average Fairly Good Good

Overall, how do you feel today?_____

Most Prominent Symptoms:

_____

_____

_____

Date of First Symptoms:_____

History of Tick Attachment? ❑Yes ❑No Date(s):_____

If yes, location on body:_____

Do you engage in any high-risk activities or hobbies? (ie: hiking, gardening, working with dogs)

❑Yes ❑No *if yes,* what?_____

Do you have indoor/outdoor pets?

❑Yes ❑No *If yes:* What type of animal?_____

How long have you had?_____

Do you let them sleep in your bed with you?_____

Are they sick?_____

Lifestyle:

❑Tobacco use_____per day ❑Vaping ❑Alcohol use_____drinks per week

Recreational Drugs: ❑Mushrooms ❑Cocaine ❑Ecstacy/MDMA ❑Marijuana ❑LSD

❑Caffeine (coffee, soda, tea) _____ per day ❑Exercise _____per week

❑Milk_____glasses per week ❑Healthy diet?_____

Your Birthplace:

_____

Other Cities/Towns where you have lived:

_____

_____

_____

Patient Name: Todays Date_____

_____ DOB_____

Past Physicians

Please list the Doctors you have seen and reason seen – Please include Naturopaths. **Begin your list with most recent Doctor**

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

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Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Doctor:_____ Date Seen:_____

Contact Info: Reason Seen:

_____ _____

Patient Name: Todays Date_____

_____ DOB_____

Past Medications:

Please list past antibiotics/medications used to treat your current condition

Medication	Dosage/frequency	How long	Rx by
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Medical Tests

Tests/Imaging	Date	Results
1) CT Scan of:		
2) CT Scan of:		
3) MRI:		
4) MRI:		
5) EEG:		
6) Nerve Conduction:		
7) Cardiac:		
8) Tilt Table:		
9) Lumbar Puncture:		
10) Endoscopy:		
11) Biopsy (of):		
12) Neuropsych Eval:		
13) Other:		
14) Other:		
15) Other:		
16) Other:		

Patient Name: Todays Date_____

_____ DOB_____

Current Medications/Supplements

Medication/Supplement	Dosage/Frequency	How Long	Who
1)			
2)			
3)			
4)			
5)			
6)			
7)			
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29)			

Patient Name: Todays Date_____

_____ DOB_____

Chronological Case History

*Please list event dates in bullet form **chronologically**, starting from earliest date and ending with most recent. Give short (2-3 sentences) summaries of each event. If important medical event details are incomplete, please bring copies of Doctor's office or hospital encounter information.*

Date/Event/Doctor/Description:

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Date/Event/Doctor/Description:

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Date/Event/Doctor/Description:

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Date/Event/Doctor/Description:

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Patient Name: Todays Date_____

_____ DOB_____

Chronological Case History, cont'd…

Date/Event/Doctor/Description:

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