Stony Brook Southampton Hospital

Functional Medicine Intake Form

Name:		
Gender:	**DOB:**	**Age:**
Physical Address:		
City:	**State:**	**Zip:**

Mailing Address:		
Contact Information:		
Home #	**Work #**	**Cell #**
Email Address:		

Emergency Contact Information:	
Name:	
Number:	

Medical Insurance Provider:
Primary Care Physician:
Phone Number:

Whom may we thank for your referral?
Comments:

240 Meeting House Lane
Southampton, NY 11968
Phone: (631) 726-8800
Fax: (631) 726-8748

MEDICAL HISTORY

Medical Conditions/Diseases/Testing: ***please check your response***

Overall how would you rate your health?	Excellent	☐	Good	☐	Fair	☐	Poor ☐
How do you rate your energy level?	High	☐	Fairly High	☐	Low	☐	Poor ☐
How do you rate your stress level?	High	☐	Tolerable	☐	Good	☐	Ideal ☐
Do you exercise at least once a week?	Yes	☐	No	☐			
How often do you exercise every week?	Once	☐	Twice	☐	Three times or more	☐	
What type of exercise do you do?	Aerobic	☐	Anaerobic/Strengthening	☐	Both	☐	

Do you have any medical conditions? ***Please check all that apply***

Heart Disease	☐	Blood clotting problems	☐	Others:
High Cholesterol or lipids	☐	Diabetes	☐	
High Blood Pressure	☐	Arthritis or joint problems	☐	
Cancer	☐	Depression	☐	
Ulcers	☐	Epilepsy	☐	
Thyroid Disease	☐	Headaches/migraines	☐	
Hormonal Related Issues	☐	Immune system disorders	☐	
Lung condition/ Asthma	☐			

Please list and note the year of any surgeries that you have had:

Have you had any of the following tests performed? ***Check and note date of last test***

Mammography	No	☐	Yes	☐	Date:	Normal	☐	Abnormal ☐
Pap Smear	No	☐	Yes	☐	Date:	Normal	☐	Abnormal ☐
Bone Density	No	☐	Yes	☐	Date:	Normal	☐	Abnormal ☐

MEDICATIONS

Please list all current medication(s):

Medication name	Strength	Date Started	How often per day

Please list any Hormones previously taken:

Medication name	Date started	Date stopped	Reason

Medications Continued..

Please check all products that you use occasionally or regularly.

- ☐ Pain Reliever
- ☐ Aspirin
- ☐ Acetaminophen (ex: Tylenol)
- ☐ Ibuprofen (ex: Motrin)
- ☐ Neproxen (ex: Aleve)
- ☐ Ketoprophen (ex: Orudis KT)
- ☐ Cough Suppressant (ex: Robitussin DM)
- ☐ Antihistamine product (ex: Chlor-Trimetone)
- ☐ Combination product (cough+cold reliever) (ex: Triaminic DM)
- ☐ Sleep Aids (ex: Excedrin PM, Unisom, Sominex, Nytol)
- ☐ Antidiarrheals (ex: Imodium, Pepto Bismol, Kaopectate)
- ☐ Diet Aids/weight loss products
- ☐ Antacids (ex: Tagamet, Pepcid, Zantac 75)
- ☐ Others:

Nutritional/ Natural Supplements: *Please identify & check all that you are using:*

- ☐ Vitamins _____
- ☐ Minerals _____
- ☐ Herbs _____
- ☐ Enzymes_____
- ☐ Nutrition/protein supplements_____
- ☐ Others_____

Allergies: *please check all that apply:*

☐ No known allergies	☐ Penicillin	☐ Others: *please list*
☐ Codeine	☐ Pet Allergies	
☐ Sulfa drug	☐ Seasonal Allergies	
☐ Morphine	☐ Nitrate Allergies	
☐ Aspirin		
☐ Food Allergies		
☐ Dye Allergies		

Please describe the allergic reaction you experienced:

FAMILY HISTORY		
Parents/Children		
Mother:	Age:_____	Condition:_____
		_____
Father:	Age:_____	Condition:_____
		_____
Sisters:	Age:_____	Condition:_____
		_____
Brothers:	Age:_____	Condition:_____
		_____
Child/Children:		
Gender:	_____	_____
☐ M ☐ F	Age:_____	Health:_____
☐ M ☐ F	Age:_____	Health:_____
☐ M ☐ F	Age:_____	Health:_____
☐ M ☐ F	Age:_____	Health:_____

Do you have a family history of any of the following? *(relation with family member)*			
Skin Conditions	☐ No	☐ Yes	Family Member(s)_____
Obesity	☐ No	☐ Yes	Family Member(s)_____
Uterine Cancer	☐ No	☐ Yes	Family Member(s)_____
Ovarian Cancer	☐ No	☐ Yes	Family Member(s)_____
Fibrocystic Breast	☐ No	☐ Yes	Family Member(s)_____
Breast Cancer	☐ No	☐ Yes	Family Member(s)_____
Heart Disease	☐ No	☐ Yes	Family Member(s)_____
Osteoporosis	☐ No	☐ Yes	Family Member(s)_____
Depression	☐ No	☐ Yes	Family Member(s)_____
Diabetes	☐ No	☐ Yes	Family Member(s)_____

ENERGY LEVEL	
How would you rate your energy level on a scale from 1-10? 1 means you barely function and 10 means you radiate energy.	____/10
Do you feel you should have more energy?	☐ Yes ☐ No
How long have you been feeling this way?	_____year(s)
Do you feel constantly tired or fatigued?	☐ Yes ☐ No
Do you wake up tired?	☐ Yes ☐ No
Do you have energy swings?	☐ Yes ☐ No
Are you run down around 4:30pm?	☐ Yes ☐ No
Do you eat something sweet when you feel this way?	☐ Yes ☐ No
Do you feel better at these times after you eat something sweet?	☐ Yes ☐ No
Are you easily exhausted with physical activity?	☐ Yes ☐ No
Do you have difficulty handling stress?	☐ Yes ☐ No
Is it difficult for you to stay up late (after midnight)?	☐ Yes ☐ No
Do you get very tired in the evening or early night?	☐ Yes ☐ No
Do you feel more tired when you are at rest than when active?	☐ Yes ☐ No
Do you have difficulty recovering after staying up late?	☐ Yes ☐ No
Do you feel like you're living in slow motion?	☐ Yes ☐ No

THYROID	
Have you ever been diagnosed with a thyroid disorder?	☐ Yes ☐ No
If yes, please note the year of the diagnosis	
Are you Hyperthyroid (high) or Hypothyroid (low)?	☐ High ☐ Low
Do you or have you ever taken thyroid medication?	☐ Yes ☐ No
If yes, for how long?	
If yes, what brand and dosage are you currently taking?	_____mg _____how often?
If not at this time, when did you quit taking medication?	

WEIGHT CONTROL	
Have you had any significant weight gain?	☐ Yes ☐ No
How many pounds?	
What year did it start?	
Do you feel you put on weight easily?	☐ Yes ☐ No
Do you have difficulty losing weight?	☐ Yes ☐ No
How long have you had this problem?	_____year(s)
Do you put on weight around your waist?	☐ Yes ☐ No
Do you put on weight around your thighs and buttocks?	☐ Yes ☐ No
Do you have a flabby abdomen?	☐ Yes ☐ No
Are you pear-shaped?	☐ Yes ☐ No
Is your upper abdomen distended?	☐ Yes ☐ No
Is your lower abdomen distended?	☐ Yes ☐ No
Do you suffer from constipation?	☐ Yes ☐ No

TEMPERATURE SENSITIVITY		
Are you sensitive to cold?	☐ Yes	☐ No
Do you hands and feet feel cold?	☐ Yes	☐ No
How long have you experienced this?	_____ Year(s)	
Do you get chills easily?	☐ Yes	☐ No
Do the palms of your hands or feet perspire unusually?	☐ Yes	☐ No
How long have you experienced this?	_____ Year(s)	
Do you have decreased perspiration?	☐ Yes	☐ No
How long have you experienced this?	_____ Year(s)	
MOOD AND MEMORY		
Do you ever feel discouraged, blue or depressed?	☐ Yes	☐ No
If yes, what percentage of the time?	_____ %	
How long have you felt this way?	☐ Yes	☐ No
Do you or have you ever taken antidepressants?	☐ Yes	☐ No
If yes, which ones?		
If yes, between what ages?		
Are you ever anxious, nervous or irritable?	☐ Yes	☐ No
Do you lose self-control?	☐ Yes	☐ No
Do you have difficulty making decisions or setting goals?	☐ Yes	☐ No
Are you less self-confident now?	☐ Yes	☐ No
If yes, how long have you been this way?		
Do you tend to isolate yourself?	☐ Yes	☐ No
Are you intolerant of noise?	☐ Yes	☐ No
Do small things set you off?	☐ Yes	☐ No
Have you noticed a decrease in mental sharpness?	☐ Yes	☐ No
Do you have poor short term memory?	☐ Yes	☐ No
Do you have trouble concentrating?	☐ Yes	☐ No

SLEEP		
How many hours do you sleep each night, on average?	_____	
Do you feel you need a lot of sleep?	☐ Yes	☐ No
Do you have trouble falling asleep at night?	☐ Yes	☐ No
Is your mind filled with thoughts as you are trying to go to sleep?	☐ Yes	☐ No
Do you wake up during the night?	☐ Yes	☐ No
Can you go back to sleep easily during the night?	☐ Yes	☐ No
Do you have nervous, anxious or restless sleep?	☐ Yes	☐ No
Do you have a tendency to go to bed late and wake up late?	☐ Yes	☐ No
Do you have difficulty waking up in the morning?	☐ Yes	☐ No
Do you wake up too early with a heavy head in the morning?	☐ Yes	☐ No
When you get up in the morning, are you rested?	☐ Yes	☐ No
Do you take something the help you sleep?	☐ Yes	☐ No
If yes, what do you use?	_____	

HAIR		
Do you have fine hair or coarse hair?	☐ Fine	☐ Coarse
How long have you had this type of hair?	_____ year(s)	
Are you eyebrows or eyelashes thinning?	☐ Yes	☐ No
Do you have hair loss or thinning of hair on your head?	☐ Yes	☐ No
Do you have dry,thick, brittle hair?	☐ Yes	☐ No
Does you hair grow slowly?	☐ Yes	☐ No
Do you have less armpit hair?	☐ Yes	☐ No
Do you have less pubic hair?	☐ Yes	☐ No
Is your hair graying?	☐ Yes	☐ No
Is your hairline receding?	☐ Yes	☐ No
Are you losing your hair on top of your head?	☐ Yes	☐ No

SKIN		
Do you have fine lines or crow's feet at the side of your eyes?	☐ Yes	☐ No
Do you have lines on your forehead?	☐ Yes	☐ No
Does the skin on your face look puffy, pale or doughy?	☐ Yes	☐ No
Is the skin on the back of your hands thin?	☐ Yes	☐ No
Do you have lines on the side of your mouth?	☐ Yes	☐ No
Do you have dry skin?	☐ Yes	☐ No
If yes, since when?	☐ Yes	☐ No
Do you have rosacea (redness on the nose and cheeks)?	☐ Yes	☐ No
Do you have eczema, psoriasis or other rashes?	☐ Yes	☐ No
Do you have age spots?	☐ Yes	☐ No
Do you have thin, vertical wrinkles above your lips?	☐ Yes	☐ No
Do your cheeks sag?	☐ Yes	☐ No
Are your nails brittle?	☐ Yes	☐ No
Do you have acne?	☐ Yes	☐ No

EYES		
Do you have swelling or puffiness in the morning?	☐ Yes	☐ No
Do you have swollen eyelids in the morning?	☐ Yes	☐ No
Do you have dark circles under your eyes?	☐ Yes	☐ No
How long have you had any of these problems?	_____ Year(s)	
Does the swelling occur often?	☐ Yes	☐ No
Do your eyes feel dry?	☐ Yes	☐ No
Do you see as brightly as before?	☐ Yes	☐ No
Do you wear corrective lenses of any sort?	☐ Yes	☐ No

MUSCULO-SKELETAL		
Do you feel your muscles are flabby or slack?	☐ Yes	☐ No
Do your joints get stiff in the morning?	☐ Yes	☐ No
Do you have arthritis? If yes, where?	☐ Yes ☐ No	_____
Do you have osteoarthritis of the hips?	☐ Yes	☐ No
Do you have muscular pain? If yes, where?	☐ Yes ☐ No	_____
Do you have bone loss or osteoporosis?	☐ Yes	☐ No
Do you suffer from low back pain?	☐ Yes	☐ No

ADVANCE DIRECTIVES

Do you have an Advanced Directive (Living Will, DNR, Health Care Proxy)? ☐ Yes ☐ No
If yes, please bring in a copy to keep on file in your chart. If no, and you would like to know more and/or wish to develop an Advanced Directive, please speak with the receptionist at the front desk, so that we may provide you with this information.

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