Choose The Natural Path LLC

Susan Ventrella, DO, ND

Initial Visit Questionnaire

Please do your best to answer as completely as you can. The more honest you are, the more I can do to help you! Bring the completed form and every medication and supplement you take to your appointment. All information is confidential and will ONLY be shared with your consent.

Date: ____________________

Name: ____

Gender: (*circle one*) Male / Female   Date of Birth: ____/____/________

Age: ____ Height: ________ Weight: __________ lbs

Marital Status: (circle one) Single / Married / Divorced / Widowed

Are you disabled in any way? If so, please describe:

____

What concerns have motivated you to come see Dr. Sue?

____

____

____

____

*Forgive me! We have some background information we **MUST** collect.*

Know that I appreciate your patience!

Social History

Please describe your home environment. Who lives with you? Do you feel safe there?

____

____

____

Are you currently working? (*circle one*) Yes / No

Occupation? ____

Do you feel stressed? (*circle one*) Yes / No

Why? What do you do to alleviate stress?

____

____

Have you ever used tobacco products? (*circle one*) Yes / No

Are you still using? (*circle one*) Yes / No

Circle all that apply:

Cigar / Pipe / Cigarettes / Chewing / Vapor / Other ______________________

Number of packs per day: ___________ x Number of years ________

How many servings of caffeine do you consume daily? (this includes coffee, tea, sodas, energy drinks, etc): _________________

How much alcohol do you consume? Daily: _________ Weekly: _____________

Do you use any other recreational drugs? (*circle one*) Yes / No

If "Yes," which ones? ____

Do you exercise? (*circle one*) Yes / No

What types of exercise do you do? How frequently?

____

____

Dietary History

Describe a normal day's intake to me:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks (when and what):

____

____

Water (what kind & how much): ____________________

Other beverages: ____________________

____

On average, how many times a week do you eat at a restaurant? ______ times per week

Any fast food? ________ times per week

Do you crave anything? (hot or cold drinks, chocolate, peanut butter, breads, sweets, alcohol, other)

____

What foods do you have trouble with/avoid? Why?

____

____

____

Important Bodily Functions

How much sleep do you get per 24-hours? ___________

Is it deep and restful? (*circle one*) Yes / No

Do you wake at night? (*circle one*) Yes / No / Sometimes

Why? ____________________

Describe your energy level to me: ____________________

____

How often do you have a bowel movement? ________________

Are they easy to pass? Please describe any issues:

____

Do you use laxatives, stool softeners, or enemas?

____

Family Medical History

Has any blood relative ever had:

- ☐ Alzheimer's
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart attack before age 55
- ☐ Stroke
- ☐ Heart Disease
- ☐ Alcoholism
- ☐ Allergies
- ☐ Depression
- ☐ Mental Disorder
- ☐ High Blood Pressure
- ☐ Suicide
- ☐ Tuberculosis
- ☐ Seizures
- ☐ Bleeding disorder
- ☐ Asthma

	Age	Medical conditions	Age at & cause of death
Father's Mother			
Father's Father			
Mother's Mother			
Mother's Father			
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			

Any blood related **Aunt** or **Uncle** with significant medical conditions?

____

____

Your Personal Medical History

Are you allergic to: (*please list*)

Drugs? ____

Foods? ____

Other? ____

Have you received any blood transfusions? (*circle one*) Yes / No   Year: ____________

Immunizations: (*indicate year received if known*)

____________ Flu

____________ Tetanus(dT)

____________ Pertussis

____________ Hepatitis B

____________ MMR

____________ Hepatitis A

____________ Zostivax

____________ Pneumovax

Others: ____

Surgical history:

YEAR	PROCEDURE

Please check all the Medical Conditions or Diagnoses you currently have or have had:

- ☐ Bone or Joint Problems
- ☐ Glaucoma
- ☐ Colitis
- ☐ Asthma
- ☐ Edema
- ☐ Cancer
- ☐ Stroke
- ☐ Pleurisy
- ☐ Ulcers
- ☐ PMS
- ☐ Infections of any kind (Lyme, Yeast, etc)
- ☐ Heart Murmur
- ☐ Emphysema /COPD
- ☐ High Blood Pressure
- ☐ Pneumonia
- ☐ High Cholesterol
- ☐ TB/Lung Disease
- ☐ Seizures/Epilepsy
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Liver Disease or Jaundice
- ☐ Digestive Problems
- ☐ Skin Disorders
- ☐ Syncope or Vertigo
- ☐ German Measles
- ☐ Syphilis or STD
- ☐ Rheumatic Fever
- ☐ Chicken Pox
- ☐ Prostate Enlargement
- ☐ Constipation
- ☐ Kidney Disease or Stones
- ☐ Diabetes
- ☐ Anxiety
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Depression
- ☐ Bleeding Disorders
- ☐ Leg Cramps
- ☐ Menopause

☐ Other: ____

List all current prescription medications:

____

____

____

List of all OTC vitamins, supplements, homeopathics, herbs, etc., that you currently use and why:

____

____

____

____

If you are a **female**, please answer the following:

Date of last menstrual period:____/____/__________

Date and result of last GYN/pelvic exam: ______________________________

Date and result of last mammogram: ______________________________

Are you or could you be pregnant? (*circle one*) Yes / No

How many times have you been pregnant? __________

The results of those pregnancies:

1. First Pregnancy:
   a. Live birth? (*circle one*) Yes / No
   b. Full term or Premature? (*circle one*)
   c. Miscarriage? (*circle one*) Yes / No
2. Second Pregnancy:
   a. Live birth? (*circle one*) Yes / No
   b. Full term or Premature? (*circle one*)
   c. Miscarriage? (*circle one*) Yes / No
3. Third Pregnancy:
   a. Live birth? (*circle one*) Yes / No
   b. Full term or Premature? (*circle one*)
   c. Miscarriage? (*circle one*) Yes / No
4. Fourth Pregnancy:
   a. Live birth? (*circle one*) Yes / No
   b. Full term or Premature? (*circle one*)
   c. Miscarriage? (*circle one*) Yes / No

Have you had an abortion(s)? (*circle one*) Yes / No