CHERYL HAMMES, D.O
6909 Royalton Rd. #104
Brecksville, OH 44141
www.drcheryl.info

Main 440-792-4096
Fax 866-517-8990

drcheryl@drcheryl.info

PERSONAL INFORMATION

Date Questionnaire Received / /	Date of Initial Consultation / /		
Above line is for office use only.			
Patient Name: First	Last	Middle Initial	
Address: Street	City		
State	Zip code	Home Phone ( )	
Work Phone ( )	Cell Phone ( )		
Email address	Fax ( )		
Age	Birth Date: Month Day Year	Sex (Circle One) Female/Male	
Social Security Number (optional)			
Place of Birth	Race/National/Ethnic Roots		
Height	Weight lbs.	Circle One: Right-handed / Left-handed / Mixed Dominance	
Occupation			
HEALTH INSURANCE INFORMATION			
Please note → We do not accept any health insurance. You are responsible for submitting your own claims.			
Primary Health Insurance	ID/Group #		
Secondary Health Insurance			
OTHER			
Primary Care Physician	Phone		
City, State	Fax		
Your local Pharmacy	Phone		
City, State	Fax		
GENERAL			
Referred by			
What brings you to our office today?			
What do you hope to get from today's visit?			

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MEDICAL HISTORY

PRIMARY DOCTOR (S)

Name	Phone Numbers	City, State	Last Visit

SPECIALISTS

Name	Specialty	Phone Numbers	City, State	Last Visit

NUTRITIONIST

Name	Phone Numbers	City, State	Last Visit

NATUROPATH (S) and/or HOMEOPATH (S)

Name	Phone Numbers	City, State	Last Visit

THERAPIST (S)

Name	Type of Therapist	Phone Numbers	City, State	Last Visit

OTHER

Name	Phone Numbers	City, State	Last Visit

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CURRENT HEALTH CONCERNS

What are you major CURRENT health problems?

Problem and Brief Description	Date of Onset	Frequency (daily, weekly…)	Severity (mild, mod or severe)

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

Why?

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PAST MEDICAL HISTORY

Include any chronic/recurring disorder or previously treated problems/diseases which no longer affect you.

Examples of chronic/recurring disorders – Recurrent Fungal Infections, Diabetes Mellitus, Chronic Fatigue, etc.
Examples of treated problems that no longer affect you – Tuberculosis, Meningitis, etc.

Condition	Past Treatments	Current Treatments	Approximate Date (s) of Treatment

Do you have a history of Learning Problems? __________ If yes, please provide details (including how they were addressed)

Provide details of any tattoos or body piercings you may have?

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WHAT MEDICATIONS ARE YOU TAKING NOW?					
Name	Dosage and # Per Day	Good Response	No Response	Bad Response	Bad then Good

WHAT VITAMINS, MINERALS and OTHER NUTRITIONAL SUPPLEMENTS ARE YOU TAKING NOW?					
Name and Form (e.g. Calcium Carbonate vs. Calcium Citrate)	Dosage (mg, mcg, IU, etc) and # Per Day	Good Response	No Response	Bad Response	Bad then Good

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OTHER MEDICATIONS AND SUPPLEMENTS
Please list any other medications you have **TAKEN IN THE PAST**? Specifically indicate any frequent use of antibiotics and/or steroids. Also, please comment as to whether you had good, bad or no response to each medication
Current medications.
Previous supplements.
Current supplements.
Have you ever used CHELATING AGENTS? If yes, please specify name, dose, route, frequency of use, reason for use, and approximate dates of starting and stopping treatment.

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HEALTH MAINTENANCE UPDATE

Test	Date	Results
Physical Examination		
Eye Exam		
Dental Exam		
Breast Exam		
Digital Rectal Exam		
Stool Occult Blood		
Cholesterol Profile		
Bone Density (DEXA) Scan		
Mammogram		
PSA		
Colonoscopy or Flexible Sigmoidoscopy		
PAP Test		
Cardiac Stress Test (Specify Type)		
Hearing Test		

SURGICAL HISTORY

Chronologically list major/minor surgeries you have had or are planning – include approximate dates and complications.

1.

2.

3.

4.

5.

6.

Any major accidents of injuries? Please describe.

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FEMALE HEALTH HISTORY

Age at first period _______	Date of last period _______	Length of cycles _____________		
History of irregular/abnormal periods? _____Yes _____No If yes, please describe				
Please check if you have a history of _____Endometriosis _____Fibroids _____Polycystic Ovarian Syndrome?				
Describe any premenstrual symptoms				
Do you have a history of abnormal PAP tests? ________ If yes, please describe				
Are you taking birth control pills? _____ If yes, for how long? _____ If no, have you ever taken them? ______				
Any known history of Infertility problems? _______ If yes, please explain				
Pregnancies:	None _______	Term Births _______	Miscarriages _______	Abortion _______
	Preemies _______	Birth weight of largest baby _______	Smallest baby _______	
	Are you currently pregnant? _________ If so, what is your due date? ___________________			
	If you have never been pregnant, do you wish to have children in the future? _____________			
	If you have children, do you plan to have more? ___________________			
	Illnesses or complications during pregnancy or labor and delivery			
	Medications taken during pregnancy or labor and delivery			
	If you have ever had a C-Section, please explain			
	Any complications for you after delivery?			
Did you (or do you plan to) breast feed your children? ____________				
Do you take any prescription medications or natural substances for peri- or post-menopausal symptoms?_______				
If yes, provide names, dosages, etc?				
Any history of breast problems (tenderness, cysts, etc.)?				
Any history of yeast infections? If yes, please explain.				

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EARLY HEALTH HISTORY

Did your mother have any known problems during her pregnancy with you (illness, stress, medications, smoking, vaccines, alcohol)?

Were you breastfed or bottle-fed? If breastfed, please indicate duration

Did you have any significant stresses in childhood or adolescence? If yes, please explain

Please check if you had any of the following childhood illnesses?

_____ Frequent Ear, Throat or other Infections _____ Colic _____ Reflux _____Meningitis _____ Thrush

_____ Asthma _____ Chicken Pox _____ Eczema _____ Frequent Colds _____ Other ________________

Did you take _______ antibiotics or _______ steroid medications frequently?

Did you ever have adverse reactions to vaccines? If yes, explain

Did you have a problem with bed-wetting? Until what age? _____________

FAMILY HISTORY

List any allergies, major illnesses, genetic diseases or problems (such as digestive issues or mental health problems) for each family member. **If any family members are deceased, please also list their age at death and cause.

Mother	
Father	
Siblings	
Maternal Grandparents	
Paternal Grandparents	
Others	

Are you or anyone in your family ADOPTED? __________ If yes, please specify who.

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SOCIAL AND LIFESTYLE HISTORY
With whom do you live? Include children, parents, relatives, friends, etc. and their ages.
Recent changes, major losses, births, deaths, divorce, remarriage, moves, etc.
List the three (3) major STRESSORS in your life?
1.
2.
3.
What is your greatest fear?
Describe any RELAXATION/stress management TECHNIQUES you use
How important is RELIGION/SPIRITUALITY in your life?
How many hours of SLEEP per night do you average? _____ Any difficulty falling asleep or waking up? ______
Quality of sleep? _______well rested _______tired upon awakening _______nighttime awakenings
EXERCISE _______ None Type ______________________ Frequency ____________________________
Recent TRAVEL (location, duration, vaccines prior to travel or illnesses during/after that you think relate to the travel):
ALCOHOL _______ Never If yes, frequency ____________ Any alcoholics in your family? ____________
TOBACCO ______ Never ______Smoked or ______Smoking _______packs/day from age _____ to _____
If still smoking, have you ever tried to quit? _________ If yes, what methods? ___________________________
Illicit DRUG use? _____ Never Used ______ from ______ to ______. Route (IV, snort, etc.)? ____________
What are your general EATING HABITS (overeat, under eat, picky, etc.)?______________________________
Do you consider yourself ______obese ______overweight ______healthy/average weight _______underweight _______unhealthy weight
Have you been on any diets? Please explain (including results and patterns of loss and gain)
Have you ever had an eating disorder? If yes, which ones (s)?

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DIETARY/NUTRITIONAL/DIGESTIVE HISTORY

Are you currently following a special diet? Please explain

Have you tried ____Gluten Free ____Casein Free ____Yeast Free ____Salicylate Free ____Atkins ____South Beach ____Low Phenols ____IgG reactive food avoidance ____Specific Carbohydrate Diet ____Low Protein ____Other____

Your diet → % for the following: _____Organic/Fresh Food ____Processed Food ____Fast Food ____Other

Known food allergies

Suspected food SENSITIVITIES

Food CRAVINGS (e.g. bread, pasta, cheese, salty foods, sodas/coffee/tea with or without caffeine, alcohol, milk, etc.)

FOODS YOU EAT – Place a √ in the appropriate column

Food	Daily	> Once per Week	Rarely	Never	Used to Eat
Cookies					
Candy					
Sweets in general					
Caffeine (soda, tea, coffee)					
Milk – Specify Type (e.g. cow's, rice, soy, etc. and whole, 2%, 1% or skim)					
Cheese					
Ice Cream					
Salty Foods					
Meat					
Pasta					
Bread – Specify Type					
Vegetables					
Fruits					
Fried Foods					
Grains					

Describe your stool pattern (frequency, color, odor, consistency)

Do you or have you ever had gastrointestinal problems? Please describe.

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ENVIRONMENTAL/ALLERGY HISTORY
LOCATION ____ City ____ Suburban ____Wooded ____Farm ____Other ______________
WATER ____ City ____ Well If you have a purification system, please describe _________________
Type of HEAT ____ Electric ____ Gas ____ Oil ____Other ___________________
Do you live near____Power lines___Woods___Industrial areas____Water →Type (ocean, swamp, etc.)_______
Does your home have a lot of ____Dust ____Mold ____Down/Feather items (pillows, stuffed animals, etc.)
Are there specific areas in your home that you suspect have issues? Please describe
Bedding ____ Synthetic ____ Down ____ Feather ____ Mattress cover
Flooring ____Wall-to-Wall Carpet ____ Area rug ____ Wood ____ Glued down ____Synthetic Pad
Window Treatment ____ Shades ____ Blinds ____ Thin curtain ____ Valence ____ Other ____________
What is your occupation?
Have you had any known exposure to harmful chemicals?
List any pets you have in that home
Do you have any known ALLERGIES to food and/or medications? If yes, please list names and describe reactions.
Are you sensitive to any of the following? Check where appropriate.
______ Perfumes/Cosmetics ______ Cleaning Products ______ Mold ______ Paint ______ Pollens/Grasses ______ Soaps ______ Animals (dander) ______ Detergents ______ Dust ______ Gasoline ______ Tobacco Smoke ______ Other, Please describe ____
Are there foods that you avoid because of how they make you feel? Please explain.

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SIGNS AND SYMPTOMS

Please check where appropriate. Leave row blank if not applicable

Current	Past	Description	Mild	Mod	Severe	Details
		Fatigue				
		Difficulty falling asleep				
		Difficulty staying asleep				
		Daytime sleepiness				
		Heat intolerance				
		Cold intolerance				
		Flushing				
		Headache – Specify Type				
		Low self esteem				
		Trouble remembering				
		Seizures				
		Anxiety				
		Depression				
		Panic attacks				
		Suicidal thoughts				
		Fainting				
		Difficulty with concentration				
		Sore throat				
		Congestion				
		Dark circles/puffiness under eyes				
		Sinus infections				
		Post nasal drip				
		Bad breath				
		Cough				
		Wheezing				
		Seasonal allergies				
		Palpitations				
		Varicose veins				

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SIGNS AND SYMPTOMS CONTINUED						
		Heart attack				
		TMJ problems				
		Muscle weakness				
		Muscle stiffness				
		Joint stiffness				
		Joint pain				
		Cold sores				
		Cracking at corner of lips				
		Nausea				
		Vomiting				
		Abdominal pain				
		Bloating				
		Belching				
		Diarrhea				
		Constipation				
		Blood in stool				
		Hemorrhoids				
		Eczema				
		Hives				
		Rash				
		Sensitive to bug bites				
		Kidney stones				
		Psoriasis				
		Reflux				
		Other				
		Other				
		Other				
Do you have any dental amalgams (silver fillings)? If so, how many? ________________________________						
Any history of dental problems?						
Any plans for special dental procedures in the future?						

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ADDITIONAL SYMPTOMS
Describe any other symptoms you would like us to know about you.
List any other history, pertinent thoughts or questions you want to address.