

Patient Questionnaire

Patient's Name: _____ Birth Date: _____
 Exact Time of Birth: _____ Birthplace: _____
 Age: _____ Marital Status (Circle): S M W D Gender (Circle): Male Female
 Address: _____
 City/State/Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ Email: _____
 Occupation or Year in School: _____
 Name of Work or School: _____
 Parent or Guardian Name (if child) _____



BETHANY KLUG, D.O.
 RESTORING HEALTH WITH
 HOLISTIC MEDICINE
 4121 W. 83RD ST. SUITE 106
 PRAIRIE VILLAGE, KS 66208
 WWW.BETHANYKLUG.COM

INSTRUCTIONS: Check applicable boxes or write your answer in the space provided

Allergies

Are you allergic to...	Are you allergic to...	Are you allergic to...
<input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Any other drugs—List:	<input type="checkbox"/> Any foods—List:
<input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Morphine		
<input type="checkbox"/> Other antibiotics—List:	<input type="checkbox"/> adhesive tape <input type="checkbox"/> alcohol	

Pharmaceutical Drugs, Oral Contraceptives, Supplements and other Natural Medicines Currently Used (Please List)

Family History

	Father	Mother	Brother				Sister				Children	Father's Parents	Mother's Parents
			1	2	3	4	1	2	3	4			
Age or year of death													
Health (well/fair/poor/deceased)													
Alcoholism													
Asthma													
Bleeding Disorder													
Cancer													
Diabetes													
Eczema/Hives													
Epilepsy/Seizures													
Glaucoma													
Autoimmune Problems													
Heart Problems													
High Blood Pressure													
Kidney Disease													
Mental Illness													
Migraine													
Osteoporosis													
Stroke													
Thyroid Disease													
Other:													

Personal History

<u>Lymphatic</u> <input type="checkbox"/> Infections – frequent <input type="checkbox"/> Ear Infections	<u>Circulation</u> <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> Stroke	<u>Heart</u> <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Heart Attack
<input type="checkbox"/> Post nasal drip – chronic	<input type="checkbox"/> Cold fingers and toes	<input type="checkbox"/> Impairments from prior infections
<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Hardening of the arteries	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Swollen “glands” – recurrent	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Valve problems <input type="checkbox"/> Heart Defect
<u>Lung</u> <input type="checkbox"/> Asthma	<u>Sensitivity</u> <input type="checkbox"/> Animal dander sensitivity	<u>Small Intestine</u> <input type="checkbox"/> Antibiotic use - frequent
<input type="checkbox"/> Bronchitis <input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Mold sensitivity	<input type="checkbox"/> Bloating <input type="checkbox"/> Gas
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Perfume sensitivity	<input type="checkbox"/> Poor Diet
<input type="checkbox"/> Respiratory Infections – recurrent	<input type="checkbox"/> Pollen sensitivity	<input type="checkbox"/> Yeast Infections
<u>Large Intestine</u> <input type="checkbox"/> Bowel habits – change in	<u>Cellular Metabolism</u> <input type="checkbox"/> Always hungry	<u>Governing Vessel</u> <input type="checkbox"/> Brain Fog
<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Low energy at specific times of day	<input type="checkbox"/> Depression <input type="checkbox"/> Manic Depression
<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Slow metabolism	<input type="checkbox"/> Headaches
<input type="checkbox"/> Gas <input type="checkbox"/> Bloating	<input type="checkbox"/> Cancer	<input type="checkbox"/> Spinal Stiffness or Pain

<u>Nervous System</u> <input type="checkbox"/> Anxiety <input type="checkbox"/> Irritability <input type="checkbox"/> Memory problems <input type="checkbox"/> Nervousness	<u>Endocrine System</u> <input type="checkbox"/> Hormone Imbalances <input type="checkbox"/> Mood Swings <input type="checkbox"/> Sleep problems <input type="checkbox"/> Snoring <input type="checkbox"/> Heat or Cold Intolerance <input type="checkbox"/> Hair Loss	<u>Urinary/Bladder</u> <input type="checkbox"/> Bed-wetting <input type="checkbox"/> Itching <input type="checkbox"/> Infections – recurrent <input type="checkbox"/> Loss of or inability to hold urine
<input type="checkbox"/> Tremors/hands shaking	<u>Skin</u> <input type="checkbox"/> Acne <input type="checkbox"/> Dryness or Cracking <input type="checkbox"/> Eczema <input type="checkbox"/> Rashes <input type="checkbox"/> Psoriasis	<input type="checkbox"/> Pain with urination
<u>Pancreas</u> <input type="checkbox"/> Diabetes <input type="checkbox"/> Low blood sugar <input type="checkbox"/> Must have meals on-time	<input type="checkbox"/> Breast Tumors <input type="checkbox"/> Degenerative Liver Disorders <input type="checkbox"/> Fatty Tumors or Lipomas <input type="checkbox"/> Problems burning Fat	<u>Trauma</u> Any <input type="checkbox"/> broken <input type="checkbox"/> cracked bones? <input type="checkbox"/> recurrent dislocations <input type="checkbox"/> knocked unconscious <input type="checkbox"/> head injury <input type="checkbox"/> poisoning <input type="checkbox"/> food <input type="checkbox"/> drug <input type="checkbox"/> chemical
<u>Spleen</u> <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Infections – recurrent <input type="checkbox"/> Low immune response	<input type="checkbox"/> Gallstones <input type="checkbox"/> Problems losing weight	<input type="checkbox"/> sprains <input type="checkbox"/> falls on tailbone
<u>Liver</u> <input type="checkbox"/> Blood disorders <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Discomfort in Liver Region	<u>Gall Bladder</u> <input type="checkbox"/> Discomfort after eating <input type="checkbox"/> Gallstones <input type="checkbox"/> Problems losing weight	<u>I am stressed out by:</u> <input type="checkbox"/> work <input type="checkbox"/> financial worries or problems <input type="checkbox"/> relatives or family <input type="checkbox"/> society
<u>Joints</u> <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Back Pain <input type="checkbox"/> Discomfort with movement <input type="checkbox"/> Weather-triggered ailments	<u>Ovary/Uterus (Women only)</u> <input type="checkbox"/> Irregular periods <input type="checkbox"/> Mood swings <input type="checkbox"/> PMS <input type="checkbox"/> Pain or discomfort with menstruation	<u>Overall Energy and Endurance</u> <input type="checkbox"/> Lack motivation or drive <input type="checkbox"/> Lack stamina or endurance <input type="checkbox"/> Lack strength
<u>Stomach</u> <input type="checkbox"/> Acid problems <input type="checkbox"/> Bloating or gas after meals <input type="checkbox"/> Digestive problems	<u>Prostate (Men only)</u> <input type="checkbox"/> Urinating more often than usual <input type="checkbox"/> Difficulty starting urine stream or slow stream <input type="checkbox"/> Prostate pain or discomfort <input type="checkbox"/> Morning erection not everyday	<u>Overall Feeling of Well Being</u> <input type="checkbox"/> Lack feeling of fulfillment - frequently <input type="checkbox"/> Lack joy and happiness - frequently <input type="checkbox"/> Lack positive outlook - frequently
<u>Muscles, Ligaments, Tendons</u> <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Rheumatism <input type="checkbox"/> Slow recovery after exercise	<u>Conception Vessel</u> <input type="checkbox"/> Infertility <input type="checkbox"/> Impotency <input type="checkbox"/> Miscarriages <input type="checkbox"/> Low Sex Drive <input type="checkbox"/> Dry Vagina <input type="checkbox"/> Fibrocystic Breasts <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Endometriosis <input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> Other Reproductive System Issues (list):	<u>Immune System Function</u> <input type="checkbox"/> Allergies <input type="checkbox"/> Chemical sensitivities <input type="checkbox"/> Work or Live in a "Sick Building" <input type="checkbox"/> Infections – frequent <input type="checkbox"/> Were you breast fed as a baby?
<u>Teeth</u> <input type="checkbox"/> Gum, Jaw or Teeth Pain or Discomfort <input type="checkbox"/> Teeth Sensitivity <input type="checkbox"/> "Silver" Fillings		List any other diseases or problems:
<u>Weight</u> Now: One year ago: Maximum: When:	<u>Kidneys</u> <input type="checkbox"/> Gout <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Swelling	
Surgery		
Have you had removed... <input type="checkbox"/> Tonsils <input type="checkbox"/> Appendix <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Uterus <input type="checkbox"/> Right ovary <input type="checkbox"/> Left ovary	Have you ever had a transfusion of... <input type="checkbox"/> Blood <input type="checkbox"/> Plasma Have you... <input type="checkbox"/> had a hernia repaired <input type="checkbox"/> had any other operations Explain:	Have you... <input type="checkbox"/> been hospitalized for any illness Explain:
Health Maintenance		
Have you had... <input type="checkbox"/> Complete childhood immunizations If not, age they were stopped: <input type="checkbox"/> a flu shot (ever) Year: <input type="checkbox"/> a tetanus shot within last 10 years	Have you had... <input type="checkbox"/> Rhogam injection <input type="checkbox"/> any other vaccines? List:	Have you had... <input type="checkbox"/> Cholesterol screening <input type="checkbox"/> Thyroid hormone screening <input type="checkbox"/> Rectal exam <input type="checkbox"/> Colonoscopy/Flexible Sigmoidoscopy
Emotions		
Are you often... <input type="checkbox"/> Depressed <input type="checkbox"/> Anxious <input type="checkbox"/> Irritable	Are you often... <input type="checkbox"/> Jumpy <input type="checkbox"/> Jittery <input type="checkbox"/> Is concentration difficult	Have you ever... <input type="checkbox"/> had counseling or psychotherapy <input type="checkbox"/> been hospitalized for psychiatric reasons <input type="checkbox"/> been prescribed psychiatric drugs

Habits

Do you...	Do you...	Do you use...
<input type="checkbox"/> Exercise adequately	<input type="checkbox"/> Have sex <input type="checkbox"/> entirely satisfactory	<input type="checkbox"/> Recreational drugs
How?	<input type="checkbox"/> With men	<input type="checkbox"/> Alcohol (drinks per week)
	<input type="checkbox"/> with women	<input type="checkbox"/> Tobacco (packs per day for years)
<input type="checkbox"/> Awaken rested	<input type="checkbox"/> Use contraception ("protection")	<input type="checkbox"/> Coffee, Soda Pop, Tea
<input type="checkbox"/> Sleep well	<input type="checkbox"/> Like your work (hours per day)	<input type="checkbox"/> Diet aids <input type="checkbox"/> Milk, Yoghurt, Cheese
<input type="checkbox"/> Average at least 8 hours sleep nightly	<input type="checkbox"/> Work indoors <input type="checkbox"/> Work outdoors	<input type="checkbox"/> Laxatives <input type="checkbox"/> Antacids
<input type="checkbox"/> Have regular bowel movements	<input type="checkbox"/> Watch TV (hours per day)	<input type="checkbox"/> Hormones

For Women Only

Menstruation History		Pregnancies...
Age at onset:	<input type="checkbox"/> cramps <input type="checkbox"/> pain with period	Number of pregnancies:
Usual duration of period days	<input type="checkbox"/> hot flashes	Number of children born alive:
Cycle length <input type="checkbox"/> < 25 <input type="checkbox"/> 25 – 32 <input type="checkbox"/> > 32	<input type="checkbox"/> using or past use of birth control pills ("the Pill")	Number of premature births:
First day of last period:	<input type="checkbox"/> abnormal pap smear	Number of miscarriages:
Flow is <input type="checkbox"/> heavy <input type="checkbox"/> medium <input type="checkbox"/> light	Year of last pap smear	Number of abortions:
<input type="checkbox"/> tension <input type="checkbox"/> depression before period	Year of last mammogram:	Any Complications? Explain:

Diet History

Favorite Food: _____

Favorite Snack Food: _____

Favorite Vegetable _____

Number of Vegetable Servings Eaten Daily: _____

Type of Bread Eaten Most Regularly: _____

Typical Breakfast _____

Typical Lunch: _____

Typical Dinner: _____

Amount of Cow's Milk Consumed Daily: _____

Oil Used for Cooking and or Salads: _____

List any food cravings: _____

Comments or additional explanation: _____

Completed by: _____ Date: _____

B.S. Klug (Signature)

_____ Date: _____

I have read the Dr. Klug's information and policies and agree to them. Dr. Klug and her associates **may** / **may not** use the email address provided by me on this form to communicate with me about treatment, payment and health care operations.

Patient, Parent or Guardian Signature: _____ Date: _____