BENCHMARK
Medical Group Inc.

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NEW NP Intake with Functional Medicine Questions

1. **GENERAL INFORMATION:**

First Name: _____ Middle Name: _____ Last Name: _____ Date of Birth: _____

Preferred Name: _____

Gender:
○ Male ○ Female

Genetic Background:
○ African ○ European ○ Native American ○ Mediterranean
○ Asian ○ Ashkenazi ○ Middle Eastern

Highest Education Level:
○ High School ○ Under-Graduate ○ Post-Graduate

Job Title: _____

Nature of Business: _____

2. Primary Address: _____ Apt./Unit #: _____

3. Primary Address: _____ Apt./Unit #: _____

4. Home Phone 1: _____ Work Phone: _____ Cell Phone: _____

Fax: _____ E-mail: _____

5. **Emergency Contact:**

Name: _____ Phone: _____

Address: _____ Apt./Unit #: _____

6. **If you do not have a primary care physician**

Physician's Name: _____ Phone: _____ Fax: _____

7. **Referred by:**

☐ Google (which words): _____ ☐ Media: _____ ☐ Family Member: _____

☐ Friend: _____ ☐ Other: _____

PHARMACY INFORMATION

8. **Primary Pharmacy:**

Name: _____ Phone: _____

Email: Fax:

Address: Apt./Unit #:

* It is extremely important that you list the pharmacy's fax number.

9. Compounding/Supplement Pharmacy:

Name: Phone:

Email: Fax:

Address: Apt./Unit #:

* It is extremely important that you list the pharmacy's fax number.

10. ALLERGIES:

	Medication/ Supplement/Food:	Reaction
1		
2		
3		

COMPLAINTS/CONCERNS

11. What do you hope to achieve in your visit with us?

12. When was the last time you felt well?

Did something trigger your change in health?
○ Yes ○ No

What makes you feel worse?

What makes you feel better?

13. Please list current and ongoing problems in order of priority:

	Describe Problem	Mild, Moderate or Severe
1		
2		
3		

14.

	Prior Treatment/Approach	Excellent, Good or Fair
1		
2		
3		

MEDICAL HISTORY DISEASES/DIAGNOSIS/CONDITIONS

Check appropriate box and provide date of onset.

15. GASTROINTESTINAL:

	Yes	Date of Onset
Irritable Bowel Syndrome		
Inflammatory Bowel Disease		
Crohn's		
Ulcerative Colitis		
Gastritis or Peptic Ulcer Disease		
GERD (reflux)		
Celiac Disease		
Other		

If other, please specify:

_____

16. CARDIOVASCULAR:

	Yes	Date of Onset
Heart Attack		
Other Heart Disease		
Stroke		
Elevated Cholesterol		
Arrythmia (irregular heart rate)		
Hypertension (high blood pressure)		
Rheumatic Fever		
Mitral Valve Prolapse		
Other		

If other, please specify:

_____

17. METABOLIC/ENDOCRINE:

	Yes	Date of Onset
Type 1 Diabetes		
Type 2 Diabetes		
Hypoglycemia		
Metabolic Syndrome		
Insulin Resistance or Pre-Diabetes		
Hypothyroidism (low thyroid)		
Hyperthyroidism (overactive thyroid)		
Endocrine Problems		
Polycystic Ovarian Syndrome (PCOS)		
Infertility		
Weight Gain		
Weight Loss		
Frequent Weight Fluctuations		
Bulimia		
Anorexia		
Binge Eating Disorder		
Night Eating Syndrome		
Eating Disorder (non-specific)		
Other		

If other, please specify:

18. CANCER:

	Yes	Date of Onset
Lung Cancer		
Breast Cancer		
Colon Cancer		
Ovarian Cancer		
Prostate Cancer		
Skin Cancer		

19. GENITAL AND URINARY SYSTEMS:

	Yes	Date of Onset
Kidney Stones		
Gout		
Interstitial Cystitis		
Frequent Urinary Tract Infections		
Frequent Yeast Infections		
Erectile Dysfunction or Sexual Dysfunction		
Other		

If other, please specify:

_____

20. MUSCULOSKELETAL/PAIN:

	Yes	Date of Onset
Osteoarthritis		
Fibromyalgia		
Chronic Pain		
Other		

If other, please specify:

_____

21. INFLAMMATORY/AUTOIMMUNE:

	Yes	Date of Onset
Chronic Fatigue Syndrome		
Autoimmune Disease		
Rheumatoid Arthritis		
Lupus SLE		
Immune Deficiency Disease		
Herpes-Genital		
Severe Infectious Disease		
Poor Immune Function		
Frequent Infections		
Food Allergies		
Environmental Allergies		
Multiple Chemical Sensitivities		
Latex Allergy		
Other		

If other, please specify:

_____

22. RESPIRATORY DISEASES:

	Yes	Date of Onset
Asthma		
Chronic Sinusitis		
Bronchitis		
Emphysema		
Pneumonia		
Tuberculosis		
Sleep Apnea		
Other		

If other, please specify:

23. SKIN DISEASES:

	Yes	Date of Onset
Eczema		
Psoriasis		
Acne		
Melanoma		
Skin Cancer		
Other		

If other, please specify:

24. NEUROLOGIC/MOOD:

	Yes	Date of Onset
Depression		
Anxiety		
Bipolar Disorder		
Schizophrenia		
Headaches		
Migraines		
ADD/ADHD		
Autism		
Mild Cognitive Impairment		
Memory Problems		
Parkinson's Disease		
Multiple Sclerosis		
ALS		
Seizures		
Other Neurological Problems		

If other, please specify:

25. PREVENTIVE TESTS AND DATE OF LAST TEST: Check box if yes and provide date.

	Yes	Date of Last Test
Full Physical Exam		
Bone Density		
Colonoscopy		
Cardiac Stress Test		
EBT Heart Scan		
EKG		
Hemoccult Test-stool test for blood		
MRI		
CT Scan		
Upper Endoscopy		
Upper GI Series		
Ultrasound		

26. INJURIES:

- ☐ Back Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Broken Bones

27. SURGERIES: Check box if yes and provide date of surgery.

	Yes	Date of Surgery
Appendectomy		
Hysterectomy +/- Ovaries		
Gall Bladder		
Hernia		
Tonsillectomy		
Dental Surgery		
Joint Replacement –Knee/Hip		
Heart Surgery–Bypass Valve		
Angioplasty or Stent		
Pacemaker		
None		
Other		

If other, please specify:

_____

28. HOSPITALIZATIONS:

☐ None

29.

	Date	Reason
1		
2		
3		

GYNECOLOGIC HISTORY (FOR WOMEN ONLY)

30. OBSTETRIC HISTORY (Check box if yes and provide number)

	YES	Number
Pregnancies		
Caesarean		
Vaginal deliveries		
Miscarriage		
Abortion		
Living Children		

31.

☐ Post PartumDepression ☐ Toxemia ☐ Gestational Diabetes Baby Over 8 Pounds

32. Breastfeeding?

○ Yes
○ No

If yes, for how long?

_____

33. MENSTRUAL HISTORY:

Age at First Period: _____

Menses Frequency: _____

Length: _____

Pain?
○ Yes ○ No

Clotting?
○ Yes ○ No

34. Has your period ever skipped?

○ Yes
○ No

If yes, for how long?

_____

35. Last Menstrual Period:

_____

36. Use of hormonal contraception such as:
☐ Birth Control Pills ☐ Patch ☐ Nuva Ring

How long? _____

37. Do you use contraception?

○ Yes
○ No

38. If yes, which ones:

○ Condom
○ IUD
○ Diaphragm
○ Partner Vasectomy

39. WOMEN'S DISORDERS/HORMONAL IMBALANCES:

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Painful Periods ☐ Heavy periods ☐ PMS

Last Mammogram: _____

Breast Biopsy/Date: _____

Last Bone Density: _____

Results:
○ High ○ Low ○ Within Normal Range

40. Are you in menopause?

○ Yes
○ No

If yes, age at menopause:

_____

41. ☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems
☐ Vaginal Dryness ☐ Decreased Libido

42. ☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches
☐ Weight Gain ☐ Loss of Control of Urine ☐ Palpitations

43. Use of hormone replacement therapy?

○ Yes
○ No

If yes, how long?

_____

MEN'S HISTORY (FOR MEN ONLY)

44. Have you had a PSA done?

- ○ Yes
- ○ No

45. If yes, PSA Level:

- ○ 0-2
- ○ 2-4
- ○ 4-10
- ○ >10

46.
- ☐ Prostate Enlargement
- ☐ Prostate infection
- ☐ Change in Libido
- ☐ Impotence
- ☐ Difficulty Obtaining an Erection
- ☐ ifficulty Maintaining an Erection
- ☐ Urgency/Hesitancy/Change in Urinary Stream
- ☐ Loss of Control of Urine

47. Nocturia (urination at night)?

- ○ Yes
- ○ No

If yes, how many times at night?

_____

GI HISTORY

48. Foreign Travel?

- ○ Yes
- ○ No

If yes, where:

_____

49. Wilderness Camping?

- ○ Yes
- ○ No

If yes, where:

_____

MEDICATIONS

50. CURRENT MEDICATIONS:

	MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE
1					
2					
3					

51. PREVIOUS MEDICATIONS: Last 10 years.

	MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE
1					
2					
3					

52. NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY):

	SUPPLEMENT AND BRAND	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE
1					
2					
3					

53. Have your medications or supplements ever caused you unusual side effects or problems?

- ○ Yes
- ○ No

54. If yes, please describe:

_____

55. Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?

- ○ Yes
- ○ No

56. Have you had prolonged or regular use of Tylenol?

- ○ Yes
- ○ No

57. Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)

- ○ Yes
- ○ No

58. Frequent antibiotics > 3 times/year?

- ○ Yes
- ○ No

59. Long term antibiotics?

- ○ Yes
- ○ No

60. Use of steroids (prednisone, nasal allergy inhalers) in the past?

- ○ Yes
- ○ No

61. Use of oral contraceptives?

- ○ Yes
- ○ No

62. FAMILY HISTORY:

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												

63. Check family members that apply:

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Othe
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Thyroid Problems												
Lupus												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												

Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Other												

If other, specify:

_____

SOCIAL HISTORY

64. SMOKING:

Currently Smoking?
○ Yes ○ No

65. If currently smoking:

How many years? _____ Packs per day: _____ Attempts to quit: _____

66. Previous Smoking:

How many years? _____ Packs per day? _____ Second Hand Smoke Exposure?
○ Yes ○ No

67. ALCOHOL INTAKE:

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits
○ None ○ 1-3 ○ 4-6 ○ 7-10 ○ > 10

68. Previous alcohol intake?
○ Yes ○ No

If yes:
○ Mild ○ Moderate ○ High

69. Are you currently using any recreational drugs?

- ○ Yes
- ○ No

If yes, what type:

_____

70. Have you ever used IV or inhaled recreational drugs?

- ○ Yes
- ○ No

71. If yes, please describe:

_____

72. SLEEP/REST:

Average number of hours you sleep per night:
○ >10 ○ 8-10 ○ 6-8 ○ < 6

73.

	Yes	No
Do you have trouble falling asleep?		
Do you feel rested upon awakening?		
Do you have problems with insomnia?		
Do you snore?		

74. Do you use sleeping aids?

- ○ Yes
- ○ No

75. If using sleeping aids, please explain:

_____
_____
_____
_____

ROLES/RELATIONSHIP

76. Marital status:
○ Single ○ Married ○ Divorced ○ Gay/Lesbian ○ Long Term Partnership ○ Widow

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

77. Do you have known adverse food reactions or sensitivities?

- ○ Yes
- ○ No

78. If yes, describe symptoms:

_____
_____
_____
_____

79. Do you have any food allergies or sensitivities?

- ○ Yes
- ○ No

80. If yes, list all:

	Allergy / Sensitivity	Reaction
1		
2		
3		