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IF YOU CANNOT KEEP YOUR APPOINTMENT: You must notify Progressive Healthcare (520-586-9111) 48 hours before your appointment (or sooner if possible) so that we can try to schedule another patient. If you do not notify us, you will be charged $100 for a missed visit.

This form must be filled out prior to each visit, if form is incomplete you may be asked to reschedule

Follow-up Health & Environmental History Questionnaire

Name: ______________________________________ Date: ____________________

Address: ___________________________ Age: ________________
____
____

Home Phone:________________________ Work Phone:________________

Does your current health significantly reduce your ability to do your job, housework, chores and/or other needed activities? ____ No, ____ A Little, ____Moderately, ____Severely

IF YES, describe: ____
____

Please describe your AVERAGE reaction to a chemical exposure in a public place (fill in the correct number of minutes, hours, or days or check "no reaction" if your do not experience the problem):

a. How long does it take before you feel as well as you did before the exposure?
___Minutes, or ___Hours, or ___Days, or ___ No reaction

b. How long

Have you seen other doctors since your last appointment with Dr. Gray? ___ Yes, ___ No. **IF YES,** list all hospitals, addresses and dates of hospitalization:
____
____

3. Have you been hospitalized since your last appointment with Dr. Gray? _____ Yes, ____No. **IF YES**, list all hospitals, addresses and dates of hospitalization:
____
____

4. List all the medications that you are currently taking, the dose and how often you take them, what they are for, whether they help, and what bothersome side effects you experience. If you have any doubt about your answers, bring the medication bottles(s) with you to your appointment. Include any shots or medications for allergies:

Name of Medication	**Dose/Frequency**	**Purpose**	**Helps?**	**Side Effects**

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5. For the symptoms and health problems listed below. If you have had the problem in the last year, **CIRCLE** the number that best describes how often the symptom occurs, or circle 7 if not sure.

Symptom	Daily to Almost Daily	Several Times/ Week	Once A Week	Several Times/ Month	Once/ Month or Less	Rarely if ever
1. Headaches	1	2	3	4	5	6
2. Numbness, tingling	1	2	3	4	5	6
3. Weakness in a body part	1	2	3	4	5	6
4. Lightheadedness and dizziness	1	2	3	4	5	6
5. Tremor or shaking	1	2	3	4	5	6
6. Muscle twitching	1	2	3	4	5	6
7. Confusion, spaciness, inability to concentrate	1	2	3	4	5	6
8. Memory problems	1	2	3	4	5	6
9. Slurred words, difficulty finding words	1	2	3	4	5	6
10. Coordination difficulties	1	2	3	4	5	6
11. Low energy, fatigue (unusual)	1	2	3	4	5	6
12.Dizziness when standing up after sitting	1	2	3	4	5	6
13.Shakiness relieved by eating	1	2	3	4	5	6
14. Poor appetite	1	2	3	4	5	6
15.Sweet cravings	1	2	3	4	5	6
16. Unusual thirst	1	2	3	4	5	6
17.Itchy, watery eyes and nose	1	2	3	4	5	6
18.Visual changes	1	2	3	4	5	6
19.Ringing of the ears	1	2	3	4	5	6
20.Changes in hearing	1	2	3	4	5	6
21.Nasal symptoms (discharge, stuffiness)	1	2	3	4	5	6
22.Sinus discomfort	1	2	3	4	5	6
23.Throat discomfort(soreness, tightness)	1	2	3	4	5	6
24.Weak voice with hoarseness	1	2	3	4	5	6
25. Reduced cold tolerance	1	2	3	4	5	6
26.Reduced heat tolerance	1	2	3	4	5	6
27.Swollen glands	1	2	3	4	5	6
28.Coughing	1	2	3	4	5	6
29.Chest discomfort (heaviness, pain)	1	2	3	4	5	6

Symptom	Daily to Almost Daily	Several Times/ Week	Once A Week	Several Times/ Month	Once/ Month or less	Rarely if ever
30. Chest tightness	1	2	3	4	5	6
31.Wheezing	1	2	3	4	5	6
32. Muscle discomfort and spasm	1	2	3	4	5	6
33.Joint discomfort	1	2	3	4	5	6
34. Rapid pulse	1	2	3	4	5	6
35.Palpitations (rapid, violent throbbing, extra or skipped beats)	1	2	3	4	5	6
36. Swelling of the ankles	1	2	3	4	5	6
37.Bruising without cause	1	2	3	4	5	6
38.Itching, rash, hives	1	2	3	4	5	6
39. Flushing of the skin	1	2	3	4	5	6
40. Reduced bladder control	1	2	3	4	5	6
41. Need to pass urine frequently	1	2	3	4	5	6
42. Insomnia	1	2	3	4	5	6
43.Frequent jerking during sleep	1	2	3	4	5	6
44. Loud snoring during sleep	1	2	3	4	5	6
45.Stopping breathing during sleep	1	2	3	4	5	6
46. Unwanted falling asleep during the daytime	1	2	3	4	5	6
47. Fingertips turning white or blue	1	2	3	4	5	6
48. Menstrual changes (women)	1	2	3	4	5	6
49.Impotence with reduced ability to maintain an erection (men)	1	2	3	4	5	6
50. Significantly reduced sex drive	1	2	3	4	5	6
51.Pain, burning in the genital area	1	2	3	4	5	6
52.Painful intercourse or other sexually related problems (circle)	1	2	3	4	5	6
53.Difficulty or discomfort with swallowing	1	2	3	4	5	6
54.Reflux of stomach acid	1	2	3	4	5	6
55.Nausea, vomiting	1	2	3	4	5	6
56.Bloating, gas	1	2	3	4	5	6
57. Abdominal discomfort (pressure, pain or cramps)	1	2	3	4	5	6
58. Other (specify): _________________________	1	2	3	4	5	6

 Patient Name: _________________

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6. List all you ate & drank in the 4 days before your appointment. Eat according to your usual custom.

	Breakfast:	Lunch:	Dinner:	Other:
Day 1				
Day 2				
Day 3				
Day 4				

7. Do you usually buy foods grown without pesticides (organic)? ___ Yes, ___ No ___ Not sure.

8. Are mood swings or other symptoms increased before breakfast or late afternoon on an empty stomach? ___ Yes, ___ No, ___ Not sure.

9a. Are your symptoms worse when using telephones, remote control devices, or answering machines? ___ Yes, ___ No, ___ Not sure.

b. Have you reacted to other electrical or electronic devices? ___ Yes, ___ No, ___ Not sure.
IF YES, describe: ____
IF YOU ANSWERED YES to question 9a or 9b above, please request a copy of our more detailed EM survey form to completed **BEFORE YOUR VISIT**.

10. Do you have pain once a week or more? ___ Yes, ___ No.
IF YES, how often? ____ Weekly; ___ 2-4 times/week; ___ Almost daily; ___ Other: ________

a. How severe is the pain usually? ___ Mild; ___ Moderate: ___ Severe.
b. How long does it usually last? ___ 1 hour or less; ___ 2-4 hours; ___ 5-8 hours; ___ Other: ________

11. Compare your health in the last few months with your health at your last visit with Dr. Ziem? ___ About the same; ___ A little better; ___ A lot better; ___ A little worse; ___ A lot worse.
IF WORSE, describe what problems have been worse: ______________________

12. Since your last office visit, describe your reactions:

a. Onset: ___ more delayed ___ as before ___ quicker
b. Duration ___ shorter ___ as before ___ longer
c. Severity ___ less ___ as before ___ worse

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13. Are you presently working outside your home? ___ Yes, ___ No; **IF YES**, compare your health during the work week to how you feel at the end of a weekend:
___ About the same; ___ Better; ___ Worse
IF NO, did you leave work because of illness? ___ Yes, date left: __________, ___ No.

14. Does your medical condition interfere with your ability to do any of the following? If it doesn't apply to you, check "N/A." Also, describe any symptoms.

	No	Yes, A Little	Yes, Moderately	Yes, A Lot	N/A	Describe any problems or symptoms if any
a. Climbing stairs?						
b. Sitting longer than 1 hour?						
c. Standing longer than 1 hour?						
d. Frequent bending?						
e. Frequent twisting?						
f. Thinking clearly while reading?						
g. Thinking clearly while doing simple arithmetic						
h. Remembering or following instructions?						
I. Writing/typing for more than an hour?						
j. Driving a car in heavy traffic?						
k. Household chores: scrubbing floors washing windows/car? Vacuuming or sweeping?						
l. Carrying groceries of 10-15 pounds?						
m. Going into public places?						
n. Frequent lifting of 5-10 pounds?						
o. Frequent walking (short distances)?						
p. Interacting with people?						
q. Maintaining a regular work schedule?						

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15. Are you currently using a filter device containing activated charcoal (be sure it contains charcoal before checking YES. (**DO *NOT* USE OZONE GENERATING FILTERS):**

	YES	NO	DON'T KNOW	BRAND
A. Car?	___	___	_____	_________________
B. Bedroom?	___	___	_____	_________________
C. Shower/bathing area?	___	___	_____	_________________
D. Entire house water supply?	___	___	_____	_________________
E. Drinking water?	___	___	_____	_________________
f. Other home areas? ______	___	___	_____	_________________
____________________	___	___	_____	_________________

16. Are you doing sauna treatments following exercise?
___ No; ___ Yes, at home; ___ Yes, commercial saunas; ___ Yes, sauna at medical facility.
IF YES, state average number of times weekly: _______. What year did you begin regular use? __________?

17. Have you gone through all personal and household products to determine which ones have pesticides, other petrochemicals, or irritating substances? ____ Yes; ____ No

18. Is your current heat: ____ Electric; ____ Natural gas; ____ Oil; ____ Other: _________

19. Do you have a gas stove, water heater, or dryer? ____ No; ____ stove; ____ water heater, ____ dryer?

20. Have you changed your mattress, pillow, bedding to all cotton? ___ Yes; ___ no

21. Do you feel you have *current* workplace exposures which seem to be aggravating your condition? ___ Yes; ___ No; ___ Not sure, ___ N/A – not working
IF YES, please list:____
____
____

22. Are any chemical pesticides (excluding boric acid) used?

	YES	NO	DON'T KNOW
A. In the home?	___	___	_____________
B. On the job?	___	___	_____________

23. Do you have any neighbors (within 1 block radius of you) who use outdoor pesticides frequently or in large amounts? ___ Yes; ___ No; ___ Not sure.

24. Are you around any other neighborhood exposures that concern you or make you sick?
___ No; ___ Yes, of concern; ___ Yes, seem to make me sick:
IFYES,describe:____
____
____

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25. Do you have a humidifier at home? ___ Yes; ___ No. **IF YES**, does the water go through a charcoal filter first? ___ Yes, ___ No, ___ Not sure.

26. Describe important things that have happened to you since your last visit with us: major exposures, reactions, other problems not detailed in your answers so far. Use extra paper if needed.

____
____
____
____

27. Describe a typical reaction, listing symptoms in order of onset, and describing the time frame. If your reactions are quite different from time to time, describe this also.

____
____
____
____

28. Describe your activities for a relatively typical day in the past month, and indicate how this differs from your last visit, if any.

____
____
____
____

29. What other problems do you face with your health, if any: physical, emotional, social, financial, sexual, legal, etc.?

____
____
____
____

30. Make a list of questions and your goals for this visit. Use extra paper if needed.

Questions:

____
____
____

Goals:

____
____
____

31. Has your health insurance covered most costs for:

a. Medical visits? ___ Yes; ___ No
b. Medical phone follow up? ___ Yes; ___ No

 Patient Name: _________________