Street Address Line 2

City

State / Province

Postal / Zip Code

Phone Number *

Please enter a valid phone number.

Email *

example@example.com

What is your occupation? *

The name of the person completing this form *

First Name

Last Name

Relationship of this person to the patient *

Please Select

How did you hear about $ J J H O D? If someone referred you to us, please let us know. We'd like to thank them! *

Please let us know what are your primary reasons for seeking care with us. Please list them in order of greatest concern.

Concern #1: greatest important *

Concern #2

Concern #3

Concern #4 - least important concern

Your are doing great! Next, let's do a Review of Systems. Please click on any of the symptoms you may be or have been experiencing and also indicate for how long you have had them.

General Symptoms

	Current	Less than one month	2-6 months	6-12 months	More than one year
Fatigue	○	○	○	○	○
Low Grade Fever	○	○	○	○	○
Anorexia	○	○	○	○	○
Heat Intolerance	○	○	○	○	○
Cold Intolerance	○	○	○	○	○
Brain Fog	○	○	○	○	○

Skin, Hair and Nails

	Current	Less than 1 month	6-12 months	2-6 months	>1 year
New rashes (if yes, note location)					
Bruising (if yes, note location)					
Cracked Lips					
Bug bite (tick or other, if yes, note location)					
Dryness					
Excessive perspiration					
Hair loss					
Hives					
Itchiness (if yes, note location)					
Lack of perspiration					
Pallor					
Brittle nails					
Peeling nails					
Thin nails					
Thickened nails					
Nail Fungal Infections					
Nail Ridges					

If you clicked rashes, bruising, bug bite, or itchiness please explain the location and details below.

Head, Eyes, Ears, Nose and Throat

	Current	Less than one month	2-6 months	6-12 months	More than one year
Light Sensitivity	○	○	○	○	○
Eye Redness	○	○	○	○	○
Poor Night Vision	○	○	○	○	○
Difficulty driving at night	○	○	○	○	○
Visual problem	○	○	○	○	○
Eye dryness	○	○	○	○	○
Headaches	○	○	○	○	○
Migraines	○	○	○	○	○
Sinusitis	○	○	○	○	○
Hearing Loss	○	○	○	○	○
Itching Ears	○	○	○	○	○

Respiratory Symptoms

	Current	Less than one month	2-6 months	6-12 months	More than one year
Shortness of breath	○	○	○	○	○
Cough	○	○	○	○	○
	○	○	○	○	○

Difficulty breathing	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯
Bronchitis	◯	◯	◯	◯	◯

Gastrointestinal

	Current	Less than one month	2-6 months	6-12 months	More than one year
Constipation	◯	◯	◯	◯	◯
Diarrhea	◯	◯	◯	◯	◯
Irritable bowel	◯	◯	◯	◯	◯
Generalized abdominal pain	◯	◯	◯	◯	◯
Sharp abdominal pain	◯	◯	◯	◯	◯
Poor digestion	◯	◯	◯	◯	◯
Excessive gas	◯	◯	◯	◯	◯
Acid reflux	◯	◯	◯	◯	◯

Cardiovascular Symptoms

	Current	Less than one month	2-6 months	6-12 months	More than one year
Chest Pain	◯	◯	◯	◯	◯
Leg or ankle swelling	◯	◯	◯	◯	◯
Elevated blood pressure	◯	◯	◯	◯	◯
Palpitations	◯	◯	◯	◯	◯
Cold extremities	◯	◯	◯	◯	◯
Clotting problem	◯	◯	◯	◯	◯

Bleeding problem	◯	◯	◯	◯	◯

Musculoskeletal

	Current	Less than one month	2-6 months	6-12 months	More than one year
Muscle pain (if yes, note location)	◯	◯	◯	◯	◯
Muscle weakness (if yes, please note location)	◯	◯	◯	◯	◯
Disc problems	◯	◯	◯	◯	◯
Back pain	◯	◯	◯	◯	◯
Short leg	◯	◯	◯	◯	◯
Calf pain	◯	◯	◯	◯	◯
Leg Cramps	◯	◯	◯	◯	◯
Decreased Range of motion	◯	◯	◯	◯	◯
Joint Pain (if yes, note location)	◯	◯	◯	◯	◯
Joint swelling (if yes, note location)	◯	◯	◯	◯	◯
Joint stiffness	◯	◯	◯	◯	◯

Did you say yes to muscle pain, muscle weakness, joint pain or swelling? Tell us more about the location of this/these symptoms here:

Neck

	Current	Less than one month	2-6 months	6-12 months	More than one year
Neck mass	○	○	○	○	○
Neck pain	○	○	○	○	○
Neck stiffness	○	○	○	○	○

Neurological

	Current	Less than 1 month	2-6 months	6-12 months	More than one year
Neuropathy/burning/pain (if yes, note location)	○	○	○	○	○
Vertigo	○	○	○	○	○
Loss of equilibrium	○	○	○	○	○
Numbness (if yes, note location)	○	○	○	○	○
Pins and needles (if yes, note location)	○	○	○	○	○
Tingling (if yes, note location)	○	○	○	○	○
Unexplained weakness	○	○	○	○	○
Trouble walking	○	○	○	○	○
Clumsiness	○	○	○	○	○
Balance problems	○	○	○	○	○
Speech problems	○	○	○	○	○
Memory problems	○	○	○	○	○
Headaches	○	○	○	○	○
Tremor (if yes, note location)	○	○	○	○	○
Incontinence stool	○	○	○	○	○
Incontinence urine	○	○	○	○	○

Seizures	○	○	○	○	○

Did you say yes to numbness, pins and needles, tingling or tremors? If so, tell us about the location of this/these symptoms here:

Psychiatric

	Current	Less than one month	2-6 months	6 to 12 months	More than one year
Depression	○	○	○	○	○
Anxiety	○	○	○	○	○
Irritability	○	○	○	○	○
Insomnia	○	○	○	○	○
Hypersomnia	○	○	○	○	○
Inability to concentrate	○	○	○	○	○
Mood changes	○	○	○	○	○
Suicidal thoughts	○	○	○	○	○

Endocrine

	Current	Less than one month	2-6 months	6-12 months	More than one year

	Current	Less than one month	2-6 months	6-12 months	More than one year
Excessive thirst	◯	◯	◯	◯	◯
Sexual dysfunction	◯	◯	◯	◯	◯
Libido change	◯	◯	◯	◯	◯
Low blood pressure	◯	◯	◯	◯	◯
Low body temperature	◯	◯	◯	◯	◯
Cold extremities	◯	◯	◯	◯	◯
Low blood sugar	◯	◯	◯	◯	◯
Light sensitivity	◯	◯	◯	◯	◯
Poor stress tolerance	◯	◯	◯	◯	◯
Weight grain	◯	◯	◯	◯	◯
Weight loss	◯	◯	◯	◯	◯
Fatigue easily	◯	◯	◯	◯	◯

Thyroid

	Current	Less than one month	2-6 months	6-12 months	More than one year
Hyperthyroid	◯	◯	◯	◯	◯
Hypothyroid	◯	◯	◯	◯	◯
Cysts/Nodules	◯	◯	◯	◯	◯
Lower neck swelling	◯	◯	◯	◯	◯

Genitourinary

	Current	Less than one month	2-6 months	6-12 months	More than one year
Frequent urination	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯

	Current	Less than one month	2-6 months	6-12 months	More than one year
Kidney Disease	◯	◯	◯	◯	◯
Bladder infections	◯	◯	◯	◯	◯
Incontinence	◯	◯	◯	◯	◯

Male Issues

	Current	Less than one month	2-6 months	6-12 months	More than one year
Impotence	◯	◯	◯	◯	◯
Prostate problems	◯	◯	◯	◯	◯

Female Issues

	Current	Less than one month	2-6 months	6-12 months	More than one year
Hot flashes	◯	◯	◯	◯	◯
Trouble with cycles	◯	◯	◯	◯	◯
PMS	◯	◯	◯	◯	◯
Non-cycle bleeding	◯	◯	◯	◯	◯
Fibroids	◯	◯	◯	◯	◯
Ovarian cysts	◯	◯	◯	◯	◯
Yeast Infections	◯	◯	◯	◯	◯
Other infections If (yes, please note below)	◯	◯	◯	◯	◯

Did you click on "other infections"? If so, tell us more about that here:

Breast Issues (Men and Women)

	Part of my history
Fibrocystic	○
Lump or mass	○
Tenderness (if yes, please note location below)	○
Nipple discharge	○
Nipple changes (shifting, retracting)	○
Insect bite(s)	○

Did you click on breast tenderness or nipple changes? Tell us more about this here:

Hematology

	Part of my history
Swollen glands (if yes, please note location)	○
Excessive bleeding	○
	○

Enlarged lymph nodes (if yes, note location)	◯
Anemia	◯
Bruising (if yes, note location)	◯

Did you click on enlarged lymph nodes or bruising? Tell us more about its location here?

You are making great progress! Now onto Personal & Family Medical History

Specific Medical History Items: It is important for our Practitioners know if you have any history of the following issues. Please check the box next to any of the following included in your past or current medical history and, if applicable, provide the year of diagnosis (or occurrence) and any treatment received.

Immune System History

	Part of my history
Mold exposure	◯
Yeast infections (oral, intestinal, skin, groin vaginal)	◯
Exposure to Lyme endemic area	◯
Tick bite and/or bulls eye rash	◯
Other major insect bites	◯
Mercury amalgams	◯
	◯

Other heavy metal exposure	◯
Multiple allergies	◯
Chemical sensitivity	◯
	◯

If you indicated any of these symptoms, please note below the date of occurrence or diagnosis and any treatment received.

Cardiovascular History

	Part of my history
Heart attack	◯
Chest pains	◯
Rhythm problem	◯
Pacemaker	◯
Valve problem	◯

If you indicated any of these symptoms, please note below the date of occurrence or diagnosis and any treatment received.

Neurological History

	Part of my history
Stroke	○
Traumatic brain injury	○
History of whiplash	○
Concussion	○

If you indicated any of these symptoms, please note below the date of occurrence or diagnosis and any treatment received.

Female Breast

	Part of my history
Abnormal radiological study (i.e. mammogram)	○
Chest or rib trauma	○
Neck or shoulder trauma	○
Trauma or injury to breast(s)	○
Breast lump(s)	○

If you indicated any of these symptoms, please note below the date of occurrence or diagnosis and any treatment received.

Well done! Let's keep going. Now let's learn about your Diagnosis History. Please click on any issues you are currently dealing with. (Any cancer diagnosis information will be found in the following section).

Medical Concerns

	Ongoing issue	Past Issue
Sun poisoning	◯	◯
Chronic fatigue	◯	◯
Multiple Chemical Sensitivities	◯	◯
Graves Disease	◯	◯
Hashimotos Thyroiditis	◯	◯
Arthritis	◯	◯
PMS	◯	◯
Fertility disorder	◯	◯
Migraines	◯	◯
Myalgia	◯	◯
Lyme Disease	◯	◯

If you indicated any of these conditions, ongoing or present, please note below the date of

occurrence or diagnosis and any treatment received. If you have not tried or are not now having treatment write "none" if applicable.

Cancer History

	Part of my history
Brain	○
Bone	○
Breast	○
Colon	○
Leukemia	○
Prostate	○
Thyroid	○
Skin	○

Other cancer diagnosis not listed above

If you indicated any of these cancers are part of your history, please tell us about the method of diagnosis (e.g. MRI, biopsy, bloodwork, etc.), year of diagnosis, and treatment you received.

Your Surgical History. Please list any surgeries you've had. Include the reason for the surgery, what year it/they occurred and if there were any complications during or after. (For example, hysterectomy, reason was for painful menses, Jan 2001, complication was scar tissue formation)

History of Injuries - please complete accordingly. Include the type of injury, details, date of the injury, your age at the time of injury and any symptoms that occurred afterward (example: broken collar bone, gymnastics fall, November 1995, age at time of injury 10, symptom afterward was neck pain)

Female History

(skip this if you are biologically a male)

Are you

- ◯ Post menopausal
- ◯ Peri-menopausal
- ◯ Having menstrual periods

If you are post- or peri-menopausal, indicate age of onset below.

At what age did your menses begin?

Were your menses

- ☐ painful
- ☐ heavy
- ☐ abnormal
- ☐ none of these
- Other

Are your menses now

- ☐ painful
- ☐ heavy
- ☐ abnormal
- ☐ other

History of Hormonal Support. Are you taking any female hormone support? (Tell us if this includes birth control and or bioidentical hormones).

What is the date of your last mammogram?

Date

What were the findings of this mammogram? Have you had any other breast studies such as MRI, ultrasound or biopsy? Tell us about this here:

Allergies. Click next to any allergies you may have. We will cover food allergies in a different section. If you do not have any allergies, please click 'none'. *

- [ ] Environmental
- [ ] Medications
- [ ] Chemical
- [ ] Herbal/Supplements
- [ ] None
- [ ] Other

If you indicated any of these allergies, please tell us about the type of allergy, the degree of the allergy (mild, moderate, severe) and what kind of reaction you experience.

Family History - please click on any of the following included in your family medical history.

	In family history
Obesity	◯
Cancer	◯
Thyroid Disorder	◯
Auto Immune Disease	◯
Lyme Disease	◯
Multiple Chemical Sensitivity	◯
Diabetes	◯

If you indicated that any of these conditions are in your family history, please tell us about type of illness (if applicable) and which family member had the condition. (e.g. X Cancer, Family History, Colon Cancer, Father). Write the family member with such history. We are most concerned about your immediate family members: mother, father, children, brother/sister, grandparents.

Your Supplements. Please tell us the names of any supplements you take on a regular

basis. Include name, dose, and frequency. If you do not take any supplements, please write none. *

Your Medications. Please tell us the names of any prescription medications you take on a regular basis. Include name, dose, frequency and the individual who prescribed it. If you do not take any medications, please write none. *

If it is more convenient for you to do so, you may upload a document of all your medications and supplements here.

Browse Files

Drag and drop files here

Have you received any vaccinations within the last 5 years? If yes, please give explanation with dates. If no, please write none. *

Tell us about your dietary habits

Click on all the following food groupings that best reflect your current diet *

- [ ] Vegan - no animal sources of food, all plant based
- [ ] Vegetarian - dairy, eggs, and/or fish are only animal sources - mostly plant-based
- [ ] Mixed - 1/2 animal sources, 1/2 plant sources
- [ ] Heavy animal sourced - more than 1/2 of diet is from animal sources, little plants
- [ ] Diet mostly processed/prepared foods (including restaurants)
- [ ] Diet 50/50 with processed and whole foods prepared at home
- [ ] Diet mostly whole foods prepared at home
- [ ] I don't buy any organic foods
- [ ] I buy some organic and/or non-GMO
- [ ] I buy mostly organic and/or non-GMO
- [ ] I buy ALL organic and/or non-GM/grass-fed/free range

Describe your typical breakfast *

Describe your typical lunch *

Describe your typical dinner *

Omar

Please check any food allergies/sensitivities AND/OR foods you're currently avoiding for other reasons

- [ ] Gluten
- [ ] Wheat
- [ ] Dairy
- [ ] Soy
- [ ] Legumes
- [ ] Nuts
- [ ] Corn
- [ ] nightshades (potatoes, tomatoes, peppers, eggplant, ashwaganda, goji berries)
- [ ] Other

Did you click "Other"? Tell us more here

Do you have any relevant previous lab work and/or other medical history documents from other providers? If yes, please bring them with you to your appointment. *

- ( ) Yes
- ( ) No

Alternatively, you may upload those documents here.

Browse Files

Drag and drop files here

We recognize that our form unfortunately does not allow you to unselect an option if you clicked on it accidentally. If you mistakenly clicked on something that is not actually part of your history, please note it here:

Wait! One more thing. Don't forget to save your work and clicking on Submit. Thank you for telling us all about your health. Aggela and his team look forward to helping you with your health goals.

Submit