



**RADIANTLY**  
H E A L T H Y

# Executive Female Patient Packet

420 5th Ave, Suite C  
Indialantic, FL 32903  
(321) 254.6803  
Fax (321) 254.6819

[www.rh-md.com](http://www.rh-md.com)  
[newpatient@rh-md.com](mailto:newpatient@rh-md.com)



**PLEASE COMPLETE THE FOLLOWING FORM.**

SAVE THIS FORM TO YOUR COMPUTER OR DEVICE AND [EMAIL TO NEWPATIENT@RH-MD.COM.](mailto:NEWPATIENT@RH-MD.COM)  
YOU MAY ALSO PRINT THE FORM, FILL IT OUT AND BRING IT INTO OUR OFFICE.



## GENERAL INFORMATION

Name: \_\_\_\_\_  
*First Middle Last*

Date of Birth: \_\_\_\_\_ Gender:  Male  Female

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

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

Employer: \_\_\_\_\_

Job Title: \_\_\_\_\_

Primary Address: \_\_\_\_\_  
*House Number and Street Apt. No.*  
\_\_\_\_\_  
*City State Zip*

Alternate Address: \_\_\_\_\_  
*House Number and Street Apt. No.*

Preferred Contact Method

Home Phone: \_\_\_\_\_  Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_  Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

OK to Receive Text Messages About Appts etc?

Emergency Contact: Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Referred by:  Website  Magazine Article  Friend/Family \_\_\_\_\_  
 Natural Awakenings  Space Coast Living  Other Doctor \_\_\_\_\_



## Health Goals

What would be your top 3 things you want to achieve with our partnership in your health and wellness journey?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

When was the last time you felt well? \_\_\_\_\_

---

---

Did Something trigger your change in health? \_\_\_\_\_

---

---

What makes you feel better? \_\_\_\_\_

---

---

What makes you feel worse? \_\_\_\_\_

---

---

How does your condition affect you? \_\_\_\_\_

---

---

What do you think is happening and why? \_\_\_\_\_

---

---

What do you feel needs to happen for you to get better? \_\_\_\_\_

---

---

## MSQ - Medical Symptom/Toxicity Questionnaire

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If related to previous questionnaire, please record your symptoms for past 48 hours.

<b>POINT SCALE</b>	0 = Never or almost never have the symptom	1 = Occasionally have it, effect is not severe
	2 = Occasionally have it, effect is severe	3 = Frequently have it, effect is not severe
	4 = Frequently have it, effect is severe	

### DIGESTIVE TRACT

- Nausea or vomiting
- Diarrhea
- Constipation
- Bloating feeling
- Belching or passing gas
- Heartburn
- Intestinal/stomach pain

TOTAL \_\_\_\_\_

### EARS

- Itchy ears
- Earaches, ear infections
- Drainage from ear
- Ringing in ears, hearing loss

TOTAL \_\_\_\_\_

### EMOTIONS

- Mood Swings
- Anxiety, irritability, aggressiveness
- Depression

TOTAL \_\_\_\_\_

### ENERGY/ACTIVITY

- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness

TOTAL \_\_\_\_\_

### EYES

- Watery or itchy eyes
- Swollen, reddened, sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel visions (does not include near or far-sightedness)

TOTAL \_\_\_\_\_

### HEAD

- Headaches
- Faintness
- Dizziness
- Insomnia

TOTAL \_\_\_\_\_

### HEART

- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

TOTAL \_\_\_\_\_

### JOINT/MUSCLES

- Pain or aches in joints
- Arthritis
- Stiffness, limitation of movement
- Pain or aches in muscles
- Feeling of weakness or tiredness

TOTAL \_\_\_\_\_

### LUNGS

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficulty breathing

TOTAL \_\_\_\_\_

### MIND

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical coordination
- Difficulty in making decisions
- Stuttering or stammering
- Slurred speech
- Learning disabilities

TOTAL \_\_\_\_\_

### MOUTH/THROAT

- Chronic coughing
- Gagging: frequent need to clear throat
- Sore throat; hoarseness; loss of voice
- Swollen/discolored tongue, gum, lips

TOTAL \_\_\_\_\_

### NOSE

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation

TOTAL \_\_\_\_\_

### SKIN

- Acne
- Hives, rashes or dry skin
- Hair loss
- Flushing or hot flashes
- Excessive sweating

TOTAL \_\_\_\_\_

### WEIGHT

- Binge eating/drinking
- Craving certain foods
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

TOTAL \_\_\_\_\_

### OTHER

- Frequent illness
- Frequent or urgent urination
- Genital itch or discharge

TOTAL \_\_\_\_\_

**GRAND TOTAL \_\_\_\_\_** Add individual scores and total each group. Add each group scores and give a grand total.

**KEY -** Optimal is less than 10    Mild Toxicity: 10-50    Moderate Toxicity: 50-100    Severe Toxicity: 100+



## Allergies

Name of Medication/Supplement/Food

Reaction

_____	_____
_____	_____
_____	_____
_____	_____

## Lifestyle Review

### SLEEP

How many hours of sleep do you get each night on average? \_\_\_\_\_

Do you have problems falling asleep?  Yes  No

Staying asleep?  Yes  No

Do you have problems with insomnia?  Yes  No

Do you snore?  Yes  No

Do you feel rested upon awakening?  Yes  No

Do you use sleeping aids?  Yes  No

If yes, explain: \_\_\_\_\_

### EXERCISE

Current Exercise Program:

ACTIVITY	TYPE	# OF TIMES PER WEEK	TIME/DURATION (MINUTES)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g. golf)			
Other:			

Do you feel motivated to exercise?  Yes  A little  No

Are there any problems that limit exercise?  Yes  No

Do you feel unusually fatigued or sore after exercise?  Yes  No

If yes, explain: \_\_\_\_\_



**NUTRITION**

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

- Vegetarian       Vegan       Allergy       Elimination       Low Fat       Low Carb
- High Protein       Blood Type       Low Sodium       No Dairy       No Wheat       Gluten Free

Other: \_\_\_\_\_

Do you have sensitivities to certain foods?  Yes  No

If yes, list food and symptoms: \_\_\_\_\_

Do you have an aversion to certain foods?  Yes  No

If yes, list food and symptoms: \_\_\_\_\_

Do you adversely react to: *(Check all that apply)*

- Monosodium glutamate (MSG)       Artificial sweeteners       Garlic/onion       Cheese       Citrus foods
- Chocolate       Alcohol       Red wine       Sulfite-containing foods (wine, dried fruit, salad bars)
- Preservatives       Food colorings       Other food substances: \_\_\_\_\_

Are there any foods that you crave or binge on?  Yes  No

If yes, what foods: \_\_\_\_\_

Do you eat 3 meals a day?  Yes  No    If no, how many \_\_\_\_\_

Does skipping a meal greatly affect you?  Yes  No

How many meals you eat out per week?  0-1       1-3       3-5       >5 meals per week

Check the factors that apply to your current lifestyle and eating habits:

- Fat eater
- Eat too much
- Late-night eating
- Dislike healthy foods
- Time constraints
- Travel frequently
- Eat more than 50% of meals away from home
- Healthy foods not readily available
- Poor snack choices
- Significant other or family members don't like health foods
- Significant other or family members have special dietary needs
- Love to eat
- Eat because I have to
- Have negative relationship with food
- Struggle with eating issues
- Emotional eater (eat when sad, lonely, bored, etc)
- Eat too much under stress
- Eat too little under stress
- Don't care to cook
- Confused about nutrition advice



**SMOKING**

Do you smoke currently?  Yes  No    Packs per day: \_\_\_\_\_    Number of years: \_\_\_\_\_

What type?  Cigarettes  Smokeless  Pipe  Cigar  E-Cig

Have you attempted to quite?  Yes  No

If yes, using what methods? \_\_\_\_\_

If you smoked previously: Packs per day: \_\_\_\_\_    Number of years: \_\_\_\_\_

Are you regularly exposed to second-hand smoke?  Yes  No

**ALCOHOL**

How many alcoholic beverages do you drink in a week? (1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)

1-3     4-6     7-10     >10     None

Previous alcohol intake?  Yes (  Mild  Moderate  High)     None

Have you ever had a problem with alcohol?  Yes  No

If yes, when? \_\_\_\_\_

Explain the problem: \_\_\_\_\_

Have you ever thought about getting help to control or stop your drinking?  Yes  No

**OTHER SUBSTANCES**

Are you currently using any recreational drugs?  Yes  No

If yes, type: \_\_\_\_\_

Have you ever used IV or inhaled recreational drugs?  Yes  No

**STRESS**

Do you feel you have an excessive amount of stress in your life?  Yes  No

Do you feel you can easily handle stress in your life?  Yes  No

How much stress do each of the following cause on a daily basis (Rate on scale of 1-10, 10 being highest)

Work     Family     Social     Finances     Health     Other

Do you use relaxation techniques?  Yes  No

If yes, how often? \_\_\_\_\_

Which techniques do you use? (Check all that apply)

Meditation     Breathing     Tai Chi     Yoga     Prayer     Other

Have you sought counseling?  Yes  No

Are you currently in therapy?  Yes  No

If yes, describe: \_\_\_\_\_

Have you ever been abused, a victim of crime, or experiences a significant trauma?  Yes  No

What are your hobbies or leisure activities? \_\_\_\_\_



**RELATIONSHIPS**

Marital status:  Single  Married  Divorced  Gay/Lesbian  Long-Term Partner  Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets) \_\_\_\_\_

Current occupation: \_\_\_\_\_

Previous occupation: \_\_\_\_\_

Do you have resources for emotional support?  Yes  No *(Check all that apply)*

Spouse/Partner  Family  Friends  Religious/Spiritual  Pets  Other: \_\_\_\_\_

Do you have a religious or spiritual practice?  Yes  No

If yes, what kind? \_\_\_\_\_

How well have things been going for you? *(Mark on a scale of 1-10, or N/A if not applicable)*

	N/A	POORLY			FINE			VERY WELL			
	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
Overall	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
At School	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your job	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your social life	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With close friends	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With sex	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your attitude	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your children	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your parents	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your spouse	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10





**WOMEN'S HISTORY**

**Obstetric History (Check box if applicable)**

- Pregnancies \_\_\_\_\_  Miscarriages \_\_\_\_\_  Abortions \_\_\_\_\_  Living children \_\_\_\_\_  
 Vaginal deliveries \_\_\_\_\_  Cesarean \_\_\_\_\_  Term births \_\_\_\_\_  Premature birth \_\_\_\_\_

Birth weight of largest baby \_\_\_\_\_ Birth weight of smallest baby \_\_\_\_\_

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, postpartum depression, issues with breast feeding, etc.?  Yes  No

If yes, please explain \_\_\_\_\_



**Menstrual History**

Age of first period \_\_\_\_\_ Date of last menstrual period \_\_\_\_\_

Length of cycle \_\_\_\_\_ Time between cycles \_\_\_\_\_

Cramping?  Yes  No Pain?  Yes  No

Have you ever had premenstrual problems? (bloating, breast tenderness, irritability, etc.?)  Yes  No

If yes, please describe: \_\_\_\_\_

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.?)  Yes  No

If yes, please describe: \_\_\_\_\_

Use of hormonal birth control:  Birth control pills  Patch  Nuva ring

Other \_\_\_\_\_ How long \_\_\_\_\_

Any problems with hormonal birth control?  Yes  No

If yes, please describe: \_\_\_\_\_

Use of other contraception?  Yes  No  Condoms  Diaphragm  IUD  Partner vasectomy

Are you in menopause?  Yes  No If yes, age at last period: \_\_\_\_\_

Was it surgical menopause?  Yes  No

If yes, explain surgery: \_\_\_\_\_

Do you currently have symptomatic problems with menopause? (Check all that apply)

- Hot flashes  Mood swings  Concentration/memory problems  Headaches  Joint pain  
 Vaginal dryness  Weight gain  Decreased libido  Loss of control of urine  Palpitations

Are you on hormone replacement therapy?  Yes  No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)? \_\_\_\_\_

**Other Gynecological Symptoms: (Check if applicable)**

Endometriosis  Infertility  Fibrocystic breasts  Vaginal infection  Fibroids

Ovarian cysts  Pelvic inflammatory disease  Reproductive cancer

Sexually transmitted disease (describe) \_\_\_\_\_

**Gynecological Screening/Procedures (If applicable, provide date)**

Last Pap test: \_\_\_\_\_  Normal  Abnormal

Last mammogram: \_\_\_\_\_  Normal  Abnormal

Last bone density: \_\_\_\_\_ Results:  High  Low  Within Normal Range

Other tests/procedures (list type and dates) \_\_\_\_\_



## FAMILY HISTORY

*Check family members that apply*

	Mother	Father	Brother(s)	Sisters(s)	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Auto Immune Diseases (such as lupus)												
Arthritis												
Kidney disease												
Thyroid problems												
Seizures/epilepsy												
Psychiatric Disorders												
Anxiety												
Eczema/Psoriasis												
Asthma												
Allergies												
Eczema												
ADHD												
Autism												
Irritable Bowel Syndrome												
Dementia												
Substance abuse												
Genetic disorders												
Other: _____												

## MEDICAL HISTORY: ILLNESSES/CONDITIONS

Check YES = a condition you currently have, CHECK PAST = a condition you've had in the past

Gastrointestinal	Yes	Past
Irritable bowel syndrome		
GERD (reflux)		
Crohn's disease/ulcerative colitis		
Peptic ulcer disease		
Celiac disease		
Gallstones		
Other:		
<b>Respiratory</b>		
Bronchitis		
Asthma		
Emphysema		
Pneumonia		
Sinusitis		
Sleep apnea		
Other:		
<b>Urinary/Genital</b>		
Kidney stones		
Gout		
Interstitial cystitis		
Frequent yeast infections		
Frequent urinary tract infections		
Sexual dysfunction		
Sexually transmitted diseases		
Other:		
<b>Endocrine/Metabolic</b>		
Diabetes		
Hypothyroidism (low thyroid)		
Hyperthyroidism (overactive thyroid)		
Infertility		
Metabolic syndrome/Insulin resistance		
Eating disorder		
Hypoglycemia		
Other:		
<b>Inflammatory/Immune</b>		
Rheumatoid arthritis		
Chronic fatigue syndrome		
Food allergies		
Environmental allergies		
Multiple chemical sensitivities		
Autoimmune disease		
Immune deficiency		
Mononucleosis		
Hepatitis		

Other:	Yes	Past
<b>Musculoskeletal</b>		
Fibromyalgia		
Osteoarthritis		
Chronic pain		
Other:		
<b>Skin</b>		
Eczema		
Psoriasis		
Acne		
Skin cancer		
Other:		
<b>Cardiovascular</b>		
Angina		
Heart attack		
Heart failure		
Hypertension (high blood pressure)		
Stroke		
High blood fats (cholesterol, triglycerides)		
Rheumatic fever		
Arythmia (irregular heart rate)		
Murmur		
Mitral valve prolapse		
Other:		
<b>Neurologic/Emotional</b>		
Epilepsy/Seizures		
ADD/ADHD		
Heartaches		
Migraines		
Depression		
Anxiety		
Autism		
Multiple sclerosis		
Parkinson's disease		
Dementia		
Other:		
<b>Cancer</b>		
Lung		
Breast		
Colon		
Prostate		
Skin		
Other:		



**MEDICAL HISTORY (cont.)**

<b>Diagnostic Studies</b>	<b>Date</b>	<b>Comments</b>
Bone density		
CT Scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Barium enema		
Other:		
<b>Injuries</b>		
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
<b>Surgeries</b>		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
<b>Hospitalization</b>	<b>Date</b>	<b>Reason</b>

## Medications/Supplements

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mc/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mc/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems?  Yes  No

If yes, describe: \_\_\_\_\_

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin?  Yes  No

Tylenol (acetaminophen)?  Yes  No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)?  Yes  No



## READINESS ASSESSMENT

*Rate on a scale of: 5 (very willing) to 1 (not willing).*

**In order to improve your health, how willing are you to:**

**Significantly modify diet:**  5  4  3  2  1

**Take several nutritional supplements each day:**  5  4  3  2  1

**Keep a record of everything you eat each day:**  5  4  3  2  1

**Modify lifestyle [‘e.g., work, demands, sleep habits]:**  5  4  3  2  1

**Practice a relaxation technique:**  5  4  3  2  1

**Engage in regular exercise:**  5  4  3  2  1

*Rate on a scale of: 5 (very confident) to 1 (not confident at all)*

**How confident are you of your ability to organize and follow through on the above health related activities?**

5  4  3  2  1

**If you are not confident of your ability, what aspects of yourself or life lead you to question your capacity to follow through?**

---

---

---

*Rate on a scale of: 5 (very supportive) to 1 (very unsupportive)*

**At the present time, how supportive do you think the people in your household will be to your implementing the above changes?**

5  4  3  2  1

*Rate on a scale of: 5 (very frequent contact) to 1 (very infrequent contact)*

**How much on-going support (e.g. telephone consults, email correspondence) from our professional staff would be helpful to you as you implement a personal health program?**  5  4  3  2  1

**Comments:** \_\_\_\_\_  
\_\_\_\_\_



**THANK YOU FOR  
COMPLETING THIS FORM.**

**PLEASE SAVE THIS FORM TO YOUR COMPUTER OR DEVICE  
AND [EMAIL TO NEWPATIENT@RH-MD.COM.](mailto:NEWPATIENT@RH-MD.COM)**

**YOU MAY ALSO PRINT THE FORM, FILL IT OUT AND  
BRING IT INTO OUR OFFICE.**