Visceral Synergy & Advanced Immune Wellness

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Patient Profile

Please complete the following forms thoroughly to assist Dr. Mariotti in his diagnosis and treatment. This will become a part of your confidential medical record and will not be shared unless you expressly authorize its release. Please print clearly.

Today's Date: _____

Last Name: _____ **First Name:**_____ **MI:**_____

Date of Birth: _____ **Age:** _____ ___M, ___F

Address: _____

Home Phone: _____ **Work Phone:** _____

Emergency Contact: _____ **Phone:** _____ **Relation:** _____

How did you find out about Advanced Immune Wellness? _____

What brings you to my office today? _____

How do you hope your life will change as a result of working with me? _____

What are the most significant changes you have made to improve your health? _____

_____

What is your most basic feeling about your health condition e.g. fear, uncertainty, resignation, anger, hopelessness, or hope?_____

What would make life more joyful for you? _____

May Dr. Mariotti contact you via email, with labs, treatment plans and education? Yes ___ No ___

If "yes" please print your email address clearly: _____ @ _____ . _____

Health Risks

Smoking (quantity/frequency): _____

Occupational health risks: ___ Yes, ___No; if yes describe_____

Other smokers in household: ___ Yes, ___ No

Method of birth control/protection:

_____

Practice "safe sex": ___ Yes, ___ No, ___ Sometimes

Any known allergies to drugs, herbs, foods, etc.

_____

Current Health Concerns

Describe top four health concerns, their duration in order of importance.

Date of onset **Description**

1. _____
2. _____
3. _____
4. _____

Describe the causes of these concerns (if known or suspected): _____

_____

Have you had the same/similar problems before? Yes___ No____

What activities worsen the problem? _____

What activities improve the problem? _____

Are your problems getting progressively worse? Yes___ No___

What treatments have you tried in order to resolve these concerns? _____

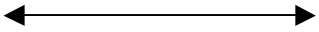
Are your problems interfering with your: Work ___ Daily routine ___ Sleep ___ All ___ Other _____

If your condition involves pain, please characterize type:

Ache ___ Sharp ___ Radiating ___ Constant ___ Intermittent ___

Please rate the amount of pain you are generally experiencing (circle one):

Minor 1 2 3 4 5 6 7 8 9 10 Severe



Previous Treatment for Health Problems

None ___

Name of doctor/hospital: _____

Address: _____

Date first seen: _____ **Date last seen:** _____

What tests were done, including x-rays? _____

Pertinent test results: _____

Condition or diagnosis: _____

How was the condition treated? _____

Results of treatment: Good ____ Fair ____ Poor ____

Please list below other doctors seen for this condition: None ____

	Name	Address	Date	Testing/treatment
1.				
2.				
3.				
4.				

Additional remarks about previous treatment: _____

_____

Current primary Care Physician: _____ **Phone:** _____

Clinic Name: _____ **Last Visit:** _____

Provider's Address: _____

Do you suffer from any other health problems from which you are not seeking consultation with me?

Yes ____ No ____ If yes, please itemize below:

	Doctor	Phone #	Condition	Date of onset
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Have you ever been placed on chemotherapy? Yes __ No__ If yes, please specify which ones and when was the last treatment? _____

Have you ever received radiation therapy? Yes __ No__ If yes, when was the last treatment? _____

_____

Health Maintenance Update

Please indicate approximate dates and results of last:

	Date:	Results:
Full Physical Exam:	_____	_____
Dental Exam:	_____	_____
Cholesterol Profile:	_____	_____
Urine Sample:	_____	_____
Blood Work:	_____	_____
Prostate Exam (M):	_____	_____
PAP/Pelvic Exam (F):	_____	_____
Mammogram (F, 40+):	_____	_____
Bone Density (DEXA) Scan:	_____	_____
Serum Vitamin D	_____	_____
Eye exam:	_____	_____
Colonoscopy or flexible sigmoidoscopy:	_____	_____
Other:	_____	_____

Female Health History

Age at first period: _____ **Date of last period:** _____ **# of pregnancies:** _____ **# live births:** _____

Date of last Pap test: _____ **History of abnormal Pap tests? Yes ____ No ____**

History of irregular periods? Yes ____ No _____ Menstrual cycle length: _____**days**

Duration of menstrual period: _____**days**

Do you experience significant menstrual cramping? Yes ____ No ____

Is heavy bleeding a problem? Yes ____ No ____

Do you have a history of endometriosis? Yes ____ No ____

Do you have a history of infertility? Yes ____ No ____

Do you have excessive unwanted hair growth? Yes ____ No ___

Do you have a tendency toward premenstrual syndrome? Yes ____ No ____ (please describe symptoms) _____

_____

Do you have a family history of breast cancer, ovarian cancer, or osteoporosis?

Yes (circle appropriate condition above) ____ No ____

Describe any current menstrual or menopausal symptoms or concerns: _____

_____

Describe any current breast problems: _____

Did you breast feed your children? Yes ____ No ____ If so, please describe length of time for each child _____

_____

Are you pregnant? _____ If so, how far along? _____

Current Medications

Please itemize all medications you are currently using or have used recently. Please be sure to include all over the counter medications and hormones, as well.

Name of drug	Reason for Use	Dose	How Long	Prescribing Doctor / self

Supplements

Please list all vitamins, minerals, herbs, and other natural products you are currently using or have used recently.

Name of natural product	Reason for Use	Dose	How Long	Prescribing Doctor / self

Please list any medications, supplements, environmental allergies, or intolerances and the reactions you have experienced to them: _____

How would you describe your general health? _____

Surgeries and Hospitalizations

Type of Surgery/Study	Date	Reason	Results

Major Illnesses, Emotional or Physical Trauma, and Accidents (not already listed)

Have you ever been in an auto accident? Yes ___ No ____ Date: _____

Describe: _____

Have you had any sports injuries? Yes ____ No ____ Date: _____

Describe: _____

Please describe any other falls, accidents, or injuries and indicate dates: _____

_____

Have you ever experienced emotional trauma? Yes ____ No ____ Date: _____

Describe: _____

Early Health History

Did your mother have any known problems during her pregnancy with you (illness, stress, medication, smoking, alcohol, traumatic delivery)? Yes __ No __ (specify) _____

Were you breastfed ___ or bottle-fed ___? If breastfed, please indicate duration _____

Was your home-life during childhood and adolescence loving and supportive, or were there significant stresses? Yes ___ No ___ (specify) _____

Please check if you had any of the following childhood illnesses:

Frequent ear infections ___ Colic ___ Eczema ___ Recurrent colds ___ Bronchitis ___ Pneumonia ___Meningitis ___

___ Other (specify) _____.

Were you on frequent or prolonged antibiotic therapy? Yes ___ No ___ (specify) _____

Did you receive standard immunizations? Yes ___ No ___

Did you experience any adverse reactions to immunizations? Yes ___ No ___ (specify) _____

Which of the following vaccinations are you aware that you have received: Pneumonia ___, Hepatitis A ___, Hepatitis B ___, Other Yes ___ No ___ (specify _____.

Do you receive a regular flu vaccination? Yes ___ No ___

Environmental Sensitivities and Allergies

Odors: Yes ___ No ___ (specify) _____

Smoke: Yes ___ No ___ (specify) _____

Soaps: Yes ___ No ___ (specify) _____

Fumes: Yes ___ No ___ (specify) _____

Perfume: Yes ___ No ___ (specify) _____

Do you have environmental allergies and how would you rate your reaction:

Dust: Yes ___ No ___ ; mild ___, moderate ___, severe ___

Grasses: Yes ___ No ___ ; mild ___, moderate ___, severe ___

Pollen: Yes ___ No ___ ; mild ___, moderate ___, severe ___

Pet dander: Yes ___ No ___ ; mild ___, moderate ___, severe ___

Mold: Yes ___ No ___ ; mild ___, moderate ___, severe ___

Lifestyle Habits

Please check major stresses:

Job ___ New retirement ___ New baby ___ Change of marital status ___ Health problems ___ Family stress ___

Financial concern ___ Abusive relationship ___ Other ___ please describe: _____

_____

Please describe your occupation: _____

Please describe the quality of major relationships in your life: _____

_____

Please indicate job satisfaction: Excellent ___ Good ___ Fair ___ Poor ___

Sleep: Time arise: _____ Time retire: _____ Naps: _____

Quality of sleep: Well-rested ____ Tired upon awaking _____ Awaken during night ____

Sleep in total darkness _____ Sleep with some light in room_____

Frequency of vacations: _____/year

Travel frequency: _____

Is your present sex life satisfactory: Yes ___ No ___

Have you experienced physical, emotional, sexual, or verbal abuse? Yes ___ No ___

Exercise *(Specify how many days/week & # of minutes)*					
Exercise	**Days / week**	**Minutes / session**	**Exercise**	**Days / week**	**Minutes / session**
Walk			**Dance**		
Run			**Yoga**		
Bike			**Skating**		
Aerobics class			**Stretching**		
Weight lifting			**Other**		

Hobbies / Activities for Pleasure *(Indicate how many times a week)*		
Activity	**Times / week**	**Times / month**

How do you relax or relieve stress? _____

_____

On a scale of 1-10 (10 being the worst you can imagine) how would you rate your stress?

Minor 1 2 3 4 5 6 7 8 9 10 Severe

Coffee (amount/day): _____

Black tea (amount/day): _____

Soda pop (amount/day): _____

Liquor: None ____ Type and amount _____/day _____/week

Number of years using tobacco: _____ **Date(s) quite:** _____

Recreational drug use: None ___ Type and frequency: _____

Former history of recreational drug use? No ___ Yes ___ Please specify _____

Digestive Function

Describe any food sensitivities / intolerances you have: Dairy ☐, Wheat ☐, Gluten ☐, Corn ☐, Sugar ☐, Eggs ☐, Citrus ☐, Coffee ☐, Alcohol ☐, Fatty foods ☐, Salty foods ☐, Spicy foods ☐, Meat ☐, Other ☐ (specify) _____

Describe any digestive problems: _____

_____

Bowel movement frequency: _____

Do you usually have to strain to have a bowel movement? Yes ___ No ___

Do you ever have blood with bowel movements? Yes ___ No ____

Do you ever see blood on the toilet paper? Yes ___ No ___

Are your stools ever black or tarry? Yes ___ No ___

Last time you received antibiotics: _____

Urinary Function

Frequency (times/day): _____ Passed easily? Yes ___ No ___

Blood or sediment present? Yes ___ No ___

Do you experience loss of bladder control? Yes ___ No ___ Frequency: _____

Do you experience difficulty starting and/or stopping urinary flow? Yes ___ No ___

Do you experience pain with urination? Yes ___ No ___ Frequency: _____

Diet History

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Typical snacks: _____

Frequency of dining out: _____ Frequency of eating fast foods: _____

Quantity of water consumed/day: _____ Is your water filtered? Yes ___ No ___

Foods you avoid: _____ Foods you crave: _____

History of eating disorder? Yes ___ No _

Family Health History

Please review the conditions listed below. Indicate those that are current health problems of a family member by writing the letter C under his/her column. Use a letter P to indicate a past problem. Spaces that do not apply should be left blank.

Condition	Father Age ____	Mother Age ____	Spouse Age ____	Brother/s Ages _____	Sisters/s Ages _____	Children Ages _____
Age at death:						
Alcoholism/ Addiction						
Alzheimer's Disease						
Allergies/ hay fever						
Asthma						
Anemia						
Arthritis (indicate type)						
Autoimmune (indicate type)						
Bleeding tendency						
Cancer ( )						
Cancer ( )						
Cancer ( )						
Cancer ( )						
Diabetes						
Depression						
Digestive problems						
Epilepsy						
Heart disease						
High blood pressure						
High cholesterol						
Kidney problems						
Liver disease						
Mental illness						
Migraine						
Obesity						
Osteoporosis						
Peptic ulcers						
Stroke						
Thyroid (low or high)						
Other (indicate)						
Other (indicate)						

Ayurvedic Constitution

On the following page you will find a relatively short summary self-test of your Ayurvedic constitution and is not meant to be exhaustive. Understanding your Ayurvedic constitution will help Dr. Mariotti in formulating future treatment plans as well increasing your self-awareness.

Instructions completing this test:

- **For each category, put a check in the box that most represents you. You may have characteristics of all three choices. Make a choice, and decide on the box that is the closest to the way you have been the most consistently throughout your life, especially your earlier years.**

- **Remember back to your earliest childhood years, and compare yourself to other children at that age. For example, were you in the chubbiest 1/3, the skinniest 1/3, or the middle 1/3, of, say, 3 year olds? Ask your parents.**
- **Make only 1 check for each category. Do not split answers. Put a check in each category.**
- **Do not overrate yourself as pitta. Since pitta is in the middle column, many people check the pitta column as a compromise.**
- **The total of all three columns should equal 20.**

Characteristic	Kapha	√	Pitta	√	Vata	√
Frame	Large frame Stout, Thick, Muscles not visible		Medium frame Moderately developed, Muscles visible		Thin, Poorly developed, Tall or short	
Body weight	Heavy, obese		Moderate		Low Prominent bones	
Disease Tendency	Mucus, congestion, water		Inflammation, Infection, Heat, Fever		Pain Nerve diseases	
Skin	Thick, oily, cool		Moist, Soft, Oily, Warm, Moles, Freckles, Acne, Pink		Dry, Rough, Cool, Thin, Cracked, Veins visible	
Complexion	Pale, white		Fair, Red (ruddy, flushed), Yellow		Brown, Black, Dull	
Hair	Thick, Oily, Wavy, Dark or Light		Soft, Oily, Fine, Yellow, red, Early gray, Balding		Brown, Black, Dry, Kinky, Wavy, Scanty, Coarse	
Joints	Thick, move smoothly		Medium, Soft, Loose		Thin, Crackling, Unstable	
Teeth	Large, White, Full		Moderate size, Soft, Pink, Bleeding gums		Protruded, Cracked, Spaces, Thin and receding gums	
Eyes	Big, Wide, Prominent, Blue, Thick, Oily, White sclera		Medium size, Penetrating gaze, Green, gray, Red or yellow sclera		Active, Dry, brown, Black, Small, Thin, Unsteady	
Elimination	Oily, Thick, Slow, Heavy		Loose, soft, oily		Constipation, hard, dry, Pain	
Activity	Lethargic, Stately		Moderate, Mid-length, Purposeful, Goal setting		Active, Talkative, Nervous, Short bursts	
Appetite	Slow, Steady		Excessive, Strong		Variable, Erratic, Low	
Thirst	Slight		Excessive		Variable	
Sleep	Heavy, Deep, Long, Excessive, Difficulty waking		Short and sound		Insomnia, Light	
Mind	Calm, Slow, Steady		Aggressive, Perceptive		Restless, Curious, Short attention	
Personality Strength	Loyalty, Calm, Contentment		Leadership		Creativity	
Personality Weakness	Greed, Attachment, Self-centered		Jealousy, Irritability, Aggression		Anxiety, Insecurity, Fear	
Memory	Slow to Memorize, Good retention		Moderate, clear		Generally poor Short term good, Long term poor	
Dreams	Water, Romance, Few Dreams		Angry, Passion, Color, Fire, Conflict		Active, Flying, Fear, Involved, Nightmares	
Speech	Slow, Melodious, Definite, Reticent		Cutting, Incisive, Argumentative, Convincing		Chaotic, Continuous, Quick, Talkative	
	Total		Total		Total	

Review of Systems

Please Indicate with a "C" if you currently have or a "P" if you previously had any of the following. Indicate type where appropriate.

	Constitutional		Mental		Neurological		Integumentary
	Severe Fatigue		Anxiety		Dizziness		Skin rash / itching
	Fever		Depression		Fainting		Skin infections
	Night sweats		Other mental issues		Recurrent headaches		Brittle nails
	Poor sleep				Migraines		Recent hair loss
	Apathy				Numbness		
					Weakness		
					Tingling		

	Endocrine		Immune System		Eye and Ear		Respiratory
	Thyroid disorder		Cancer		Loss of hearing		Freq. Sore throats
	Diabetes		Autoimmune		Ringing in ears		Freq. sinus infections
	Other:		Allergies		Recent loss of vision		Asthma
			Hay fever		Eye pain		Difficulty breathing
			Lymph nodes enlarged		Dry eyes		Shortness of breath
			Recurrent colds & flu		Recurrent sinusitis		Chronic bronchitis
							Chronic cough
							Tuberculosis
							Pneumonia (bacterial)
							Pneumonia (viral)
							Chest pain

	Gastrointestinal		Cardiology / Hematology		Genitourinary		Gynecological
	Stomach ulcers		Chest pain		Kidney failure		Menstrual cramps
	Acid reflux		Heart disease		Kidney infection		PMS
	Gas and bloating		Heart failure		Kidney stones		Menopause
	Constipation		Stroke		Bladder infection		Heavy menstrual flow
	Diarrhea (infectious)		Irregular heart beat		STD – Chlamydia		Hot flashes
	Diarrhea (bloody0		Hemorrhoids (external)		STD – HIV		Irregular cycles
	Blood in stools		Hemorrhoids (internal)		STD – HPV		Densities of breast
	Persistent nausea		Frequent nose bleeds		STD – syphilis		Other breast issues
	Recurrent vomiting		Varicose veins		STD – other		Breast discharge
	Liver disease		Poor circulation		Prostate enlargement		Vaginal discharge
	Hepatitis		Anemia		Sexual problems		
	Abdominal pain		Blood diseases		Loss of libido		
			Easy bruising				

	Musculoskeletal		Metabolic	Other (write in)
	Arthritis		Loss of appetite	
	Neck pain		Weight gain	
	Upper back pain		Weight loss	
	Mid-back pain		Weight redistribution	
	Low back pain			
	Leg pain			
	Arm pain			
	Stiffness_____			
	Bursitis _____			
	Hot / swollen joints			
	Ankle swelling			
	Fibromyalgia			