

Grapevine Functional Medicine

Wellness & Immune System Questionnaire

Name: \_\_\_\_\_

D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Eyes/Nose/Throat	Current	Past	Never	Gastrointestinal	Current	Past	Never	Pain	Current	Past	Never	General	Current	Past	Never
Hard of hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gas/bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tingling/numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sports injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carpal tunnel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constant hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disc problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained perspiration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine	Current	Past	Never	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deviated septum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other conditions/concerns			
Chronic sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	Current	Past	Never	Please list below:	Current	Past	Never
Abnormal sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad tonsils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	Current	Past	Never	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Color changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nail changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning/itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes/Irritation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial sinus pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	Current	Past	Never		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus/head pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores (canker)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fungus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Warts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers/blisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Keloids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restless leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotic use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	Current	Past	Never						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flu shot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During which seasons do symptoms occur?  Summer  Fall  Winter  Spring

Are symptoms worse in the morning, afternoon, or evening? Explain: \_\_\_\_\_

Are symptoms worse at home, work/school, or other location? List: \_\_\_\_\_

Current OTC medications (list): \_\_\_\_\_

Current Rx medications (list): \_\_\_\_\_

Current supplements (list): \_\_\_\_\_

Previous surgeries (list): \_\_\_\_\_