United Wellness
905-B Herndon Parkway, Herndon, VA 20170
Tel: (703) 437-8195

For- Sushma Hirani, MD

Personal Profile (please print) **Date :** _____

Last Name _____ Date of Birth _____ Age _____

First Name _____ Home Phone _____ Race _____

Address _____ Work Phone _____ Height _____

City _____ Cell Phone _____ Weight _____

State _____ E-Mail _____ Sex Male □ Female □

Zip Code _____ SSN _____ Adopted Yes □ No □

Medical Provider

How did you learn about United Wellness ?

The reason I am seeking care and treatment at United Wellness is:

Medical Profile History	(check boxes if applicable) Self	Father	Mother	Grand Parent	Brother / Sister	Uncle/ Aunt
Breast Cancer	□	□	□	□	□	□
Uterine Cancer	□	□	□	□	□	□
Ovarian Cancer	□	□	□	□	□	□
Prostate Cancer	□	□	□	□	□	□
Heart Attack	□	□	□	□	□	□
Stroke	□	□	□	□	□	□
Blocked Arteries	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□
Colon Cancer	□	□	□	□	□	□
Blood disorders	□	□	□	□	□	□
Osteoporosis/penia	□	□	□	□	□	□
Other Cancers	□	□	□	□	□	□
Alzheimer's Disease	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Hypothyroidism	□	□	□	□	□	□
Neurological Problems	□	□	□	□	□	□

Lifestyle Profile
(Enter number or yes/no)

Marital Status? _____
Number of children, if any _____
What is your occupation? _____
Do you smoke? **Yes** □ **No** □
Do you use recreational drugs? **Yes** □ **No** □
Do you drink alcohol? **Yes** □ **No** □
If so, what kind ? _____
How many drinks per wk? _____
Aerobic exercise (hours per wk) _____
Weight training (hours per wk) _____
Please describe:_____
_____
_____
Do you take time for any hobbies? If so, which ones?_____
_____

Past Surgeries, Traumas, Accidents	
1	
2	
3	
4	
5	
6	

Allergies	
1	Medications:
2	Food:
3	Environmental/Other:
4	Do you have difficulty tolerating herbs? □ Yes □ No □ Unknown

Current Medications		
	Name	**Dose per day**
1		
2		
3		
4		
5		
6		
7		

Current Nutritional Supplements and/or Herbs		
	Name	**Dose per day**
1		
2		
3		
4		
5		
6		
7		

Medical History

(Past and Present - Check all that apply)

□ Aids	□ Anemia	□ Seasonal Allergies
□ Angina	□ Aortic Aneurysms	□ Artificial Heart Valve
□ Artificial Joints	□ Frequent Bladder Infections	□ Gall Stones
□ Autoimmune Diseases	□ Asthma	□ Congenital Heart Disease
□ Depression	□ Dermatitis	□ Developmentally Disabled
□ Leg edema/swelling	□ Emphysema/ Bronchitis	□ Memory Loss
□ Endometriosis	□ Hypoglycemia	□ Epilepsy/ Seizures
□ Heart Murmur	□ Heart Pacemaker	□ Headaches/Migraines
□ Hepatitis B or C	□ Irritable Bowel Disease	□ Kidney Trouble/Disease
□ Liver Disease	□ Low Back Pain	□ Mitral Valve Prolapse
□ Multiple Sclerosis	□ Low platelets	□ Fibroids
□ Sickle Cell Disease	□ Gall Bladder Disease	□ Thyroid Problems
□ Tuberculosis	□ Tumors	□ Venereal Disease
□ Prostate Problems	□ Congestive Heart Failure	□ Gastrointestinal problems
□ Diverticular Disease	□ Acid reflux	□ Other_____

Personal History

How many bowel movements do you have in a day? _____ Are they well formed? □ Yes □ No

If not, please describe the consistency_____

Have you seen any blood in your stool? □ Yes □ No If so, was it □ bright red □ dark/black stools

Date of last colonoscopy and results, if applicable_____

Describe any bladder problems_____

Do you have trouble falling asleep? □ Yes □ No Staying asleep? □ Yes □ No

Please describe_____

What is your usual bedtime?_____ Wake time?_____

Upon awakening in the morning do you usually feel □ tired □ well rested

Do you get at least 15 minutes of sunshine a day without sunscreen? □ Yes □ No

Do you get sick easily (respiratory/viral infections)? □ <1/year □ 2-3/year □ 4-5/year □ >6/year

Dental history: (Check all that apply) □ amalgams/silver fillings □ bridge(s) □ implant(s)
□ denture(s) □ crown(s) □ periodontal disease □ jaw pain

When was your last complete physical?_____

When was your last dental visit? _____

Food Profile

How many times do you eat per day (including snacks)? …… _____

Is most of your food □ home cooked □ pre-packaged □ from restaurants _____

What kind of salt do you use in your food?..... _____

What percentage of your food is organic?..... _____

How many cups of <u>water</u> do you drink per day? ……..… _____

Please circle the appropriate number below regarding how often you consume certain foods

Key: 0= Do not consume or use 2= Consume or use weekly
1= Consume or use 2-3 times monthly 3= Consume or use daily

Artificial sweeteners	0 1 2 3	Fast foods	0 1 2 3	Tap water	0 1 2 3
Candy, desserts, sugar	0 1 2 3	Fried foods	0 1 2 3	Bottled water	0 1 2 3
Carbonated beverages	0 1 2 3	Margarine	0 1 2 3	Whole grains	0 1 2 3
Caffeinated beverages	0 1 2 3	Milk poducts	0 1 2 3	Nuts/Seeds	0 1 2 3
White flour/baked goods	0 1 2 3	Soy products	0 1 2 3	Fruits	0 1 2 3
Luncheon meats	0 1 2 3	Fish	0 1 2 3	Vegetables	0 1 2 3
Beef/Pork	0 1 2 3	Chicken/Turkey	0 1 2 3	Beans/Lentils	0 1 2 3

Cardiovascular System

<u>Key:</u> 1= Mild (occurs monthly), 2 = Moderate (occurs weekly), 3= Severe (occurs daily)
Leave blank if symptom does not occur

Aware of heavy and/or irregular breathing		Ankles swell, especially at end of day	
Discomfort at high altitudes		Cough at night	
"Air hunger" or sigh frequently		Blush or face turns red for no reason	
Compelled to open windows in a closed room		Dull pain or tightness in chest and/or radiates into arm, worse with exertion	
Shortness of breath with moderate exertion			
		Muscle cramps with exertion	

Cardiovascular Risks (Check all that apply)

1 Men: above age 55	
2 Women: above age 65	
3 History of Heart or Arterial Disease	
4 History of Diabetes Mellitus	
5 Smoker	
6 Sedentary lifestyle/ Obesity	
7 High Blood Pressure	
8 Father had history of heart disease at 55 or younger	
9 Mother had history of heart disease at 65 or below	

Women's Health History

Age at start of menstruation _____ First date of last period _____

Average # of days between periods _____ Average # of days of bleeding _____

Cycles are generally (check one) □ Fairly regular □ Irregular □ No periods

Last pap _____ How often? _____ Any abnormal paps? _____

Last mammogram _____ Any abnormal? _____

Pregnancies # _____ Living children # ____ Miscarriages # ____ Abortions # _____

Vaginal deliveries# _____ C-sections # _____

Any complications during pregnancy or childbirth? _____

Did you breastfeed your children? _____ If so, how long? _____

Have you used birth control □ pills □ patches □ shots? If so, for how long?_____

Have you ever been on HRT (Hormone Replacement Therapy)? _____

Please list your five major health concerns in order of importance:

1 _____

2 _____

3 _____

4 _____

5 _____

Metabolic Assessment

Please circle the appropriate number 0-3 below (0 as the least/never to 3 as the most/always)

Category I

Feel that bowels do not empty completely…… 0 1 2 3
Lower abdominal pain relief by passing stool or gas…….. 0 1 2 3
Alternating constipation and diarrhea……. 0 1 2 3
Diarrhea…….. 0 1 2 3
Constipation…… 0 1 2 3
Hard, dry, or small stool…… 0 1 2 3
Coated tongue or fuzzy debris on tongue……. 0 1 2 3
Pass large amount of foul smelling gas…….. 0 1 2 3
More than 3 bowel movements daily…….. 0 1 2 3
Use laxatives frequently…….. 0 1 2 3

Category II

Excessive belching, burping, or bloating…… 0 1 2 3
Gas immediately after a meal……..…… 0 1 2 3
Offensive breath…… 0 1 2 3
Difficult bowel movements..…… 0 1 2 3
Sense of fullness during and after meals…….. 0 1 2 3
Difficulty digesting fruits and vegetables;
undigested food found in stools…….. 0 1 2 3

Category III

Stomach pain, burning, or aching
1-4 hours after eating..…… 0 1 2 3
Use antacids…….. 0 1 2 3
Feel hungry 1-2 hours after eating……. 0 1 2 3
Heartburn when lying down or bending forward……. 0 1 2 3
Temporary relief from antacids, food, milk
or carbonated beverages……. 0 1 2 3
Digestive problems subside with rest/relaxation…….. 0 1 2 3
Heartburn due to spicy foods, chocolate, citrus,
peppers, alcohol, and caffeine…… 0 1 2 3

Category IV

Roughage and fiber cause constipation……. 0 1 2 3
Indigestion and fullness lasts 2-4 hours after eating…… 0 1 2 3
Pain, tenderness, soreness, on left side under rib cage…. 0 1 2 3
Excessive passage of gas…….. 0 1 2 3
Nausea and/or vomiting……..……. 0 1 2 3
Stool undigested, foul smelling, mucus like,
greasy or poorly formed…….. 0 1 2 3
Frequent urination……. 0 1 2 3
Increased thirst and appetite…… 0 1 2 3
Difficulty losing weight…… 0 1 2 3

Category V

Greasy or high fat foods cause distress……. 0 1 2 3
Lower bowel gas or bloating several hours
after eating…… 0 1 2 3
Bitter, metallic taste in mouth, especially in morning…… 0 1 2 3
Unexplained itchy skin……. 0 1 2 3
Yellowish cast to eyes…… 0 1 2 3
Stool color alternates from clay colored to normal brown……. 0 1 2 3
Reddened skin, especially palms……..…… 0 1 2 3
Dry/ flaky skin or hair…….. 0 1 2 3
History of gall bladder attacks or stones…….. 0 1 2 3
Have you had your gallbladder removed…….. 0 1 2 3

Category VI

Irritible, shaky, or lightheaded between meals…… 0 1 2 3
Energized after eating…….. 0 1 2 3
Difficulty eating large meals in the morning…….. 0 1 2 3
Energy level drops in the afternoon……... 0 1 2 3
Crave sugar and sweets in the afternoon……..…… 0 1 2 3
Wake up the middle of the night……. 0 1 2 3
Difficulty concentrating before eating……..…… 0 1 2 3
Depend on coffee to keep yourself going…..…… 0 1 2 3
Agitated, easily upset, or nervous between meals……. 0 1 2 3

Category VII

Fatigued after meals……..……. 0 1 2 3
Crave sugar and sweets after meals……..…… 0 1 2 3
Need stimulants such as coffee after meals……..... 0 1 2 3
Difficulty losing weight…..……. 0 1 2 3
Waist girth is larger than hip girth…….. 0 1 2 3
Urinate often…… 0 1 2 3
Increased thirst and appetite…….. 0 1 2 3
Gain weight under stress……..…… 0 1 2 3
Difficulty falling asleep……. 0 1 2 3

Category VIII

Cannot stay asleep…….. 0 1 2 3
Crave salt…….. 0 1 2 3
Slow starter in the morning……. 0 1 2 3
Afternoon fatigue……. 0 1 2 3
Dizziness when standing up quickly…… 0 1 2 3
Afternoon headaches……. 0 1 2 3
Headaches with exertion or stress…….. 0 1 2 3
Weak nails……..…… 0 1 2 3

Category IX

Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under high amounts of stress	0 1 2 3
Gain weight when under stress	0 1 2 3
Wake up tired even after 8 or more hours of sleep	0 1 2 3
Excessive perspiration even with little or no activity	0 1 2 3

Category X

Tired, sluggish	0 1 2 3
Feel cold- hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight even with low calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression, lack of motivation	0 1 2 3
Morning headaches that wear off as day progresses	0 1 2 3
Outer third of eyebrow is thinning	0 1 2 3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XI

Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category XII

Diminished sex drive	0 1 2 3
Menstual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars without symptoms	0 1 2 3

Category XIII

Increased sex drive	0 1 2 3
Tolerance to sugars reduced	0 1 2 3
"Splitting" type headaches	0 1 2 3

Category XIV (Males Only)

Difficulty urinating; dribbling	0 1 2 3
Frequent urination	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel evacuation	0 1 2 3
Leg nervousness at night	0 1 2 3

Category XV (Males Only)

Decreased libido	0 1 2 3
Decreased spontaneous morning erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decrease in physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

Category XVI (Menstruating Females Only)

Are you perimenopausal	Yes No
Alternating menstrual cycle lengths	Yes No
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast tenderness during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritible and depressed during menses	0 1 2 3

Category XVII (All Females)

Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Increased vaginal pain, dryness, or itching	0 1 2 3
Muscle and/or joint aches and pains	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Hair loss/thinning	0 1 2 3
Irritibilty/anxiety	0 1 2 3
Headaches	0 1 2 3
Bone loss	0 1 2 3

NTAF Questionnaire

Section A

Memory noticibly declining	0 1 2 3
Hard time remembering names and phone numbers	0 1 2 3
Ability to focus noticeably declining	0 1 2 3
Becoming harder to learn things	0 1 2 3
Hard time remembering appointments	0 1 2 3
Temperament getting worse in general	0 1 2 3
Losing attention span endurance	0 1 2 3
Feel down or sad	0 1 2 3
Fatigue when driving compared to past	0 1 2 3
Walk into rooms and forget why	0 1 2 3
Pick up your cellphone and forget why	0 1 2 3

Section B

	0 1 2 3
Stress level high	0 1 2 3
Often feel you have something that must be done	0 1 2 3
Feel you never have time for yourself	0 1 2 3
Often feel you are not getting enough sleep/rest	0 1 2 3
Find it difficult to get regular exercise	0 1 2 3
Feel uncared for by people in your life	0 1 2 3
Feel you are not accomplishing your life's purpose	0 1 2 3
Sharing your problems with someone is difficult	0 1 2 3

Section 1 - S

Losing pleasure in hobbies/interests	0 1 2 3
Feel overwhelmed with ideas to manage	0 1 2 3
Feelings of inner rage (anger)	0 1 2 3
Feelings of paranoia	0 1 2 3
Feel sad or down for no reason	0 1 2 3
Feel like you are not enjoying life	0 1 2 3
Feel like you lack artistic appreciation	0 1 2 3
Feel depressed in overcast weather	0 1 2 3
Losing enthusiasm for your favorite activities	0 1 2 3
Losing enjoyment for your favorite foods	0 1 2 3
Losing enjoyment of friendships and relationships	0 1 2 3
Difficulty falling into a deep restful sleep	0 1 2 3
Feelings of dependency on others	0 1 2 3
Feel more susceptible to pain	0 1 2 3
Feelings of unprovoked anger	0 1 2 3
Losing interest in life	0 1 2 3

Section 2 - D

Feelings of hopelessness	0 1 2 3
Self destructive thoughts	0 1 2 3
Inability to handle stress	0 1 2 3
Anger and aggression while under stress	0 1 2 3
Feel you are not rested even after long hours of sleep	0 1 2 3
Prefer to isolate yourself from others	0 1 2 3
Unexplained lack of concern for family and friends	0 1 2 3
Easily distracted from your tasks	0 1 2 3
Inability to finish tasks	0 1 2 3
Feel the need to consume caffeine to stay alert	0 1 2 3
Feel libido has been decreased	0 1 2 3
Lose your temper for minor reasons	0 1 2 3
Have feelings of worthlessness	0 1 2 3

Section 3 - G

Feel anxious or panic for no reason	0 1 2 3
Have feelings of dread or impending doom	0 1 2 3
Feel knots in your stomach	0 1 2 3
Feelings of being overwhelmed for no reason	0 1 2 3
Feelings of guilt about everyday decisions	0 1 2 3
Mind feels restless	0 1 2 3
Difficult to turn your mind off when you want to relax	0 1 2 3
Have disorganized attention	0 1 2 3
Worry about things you were not worried about before	0 1 2 3
Feelings of inner tension and inner excitability	0 1 2 3

Section 4 - ACH

Feel your visual memory (shapes and images) has decreased	0 1 2 3
Feel your verbal memory has decreased	0 1 2 3
Memory lapses	0 1 2 3
Creativity been decreased	0 1 2 3
Diminished comprehension	0 1 2 3
Difficulty calculating numbers	0 1 2 3
Difficulty recognizing objects and faces	0 1 2 3
Feel like your opinion about yourself has changed	0 1 2 3
Experience excessive urination	0 1 2 3
Experiencing slower mental response	0 1 2 3

Consent

I have completed the above information as accurate as possible and to the best of my knowledge. By supplying an email address, I consent to being contacted by Dr Hirani, if needed, at the email address provided.

Patient Signature _____ Date _____

Parent/Responsible Party Signature _____ Relationship _____