

**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	(check boxes if applicable)						Lifestyle Profile (Enter number or yes/no)			
	History	Self	Father	Mother	Grand Parent	Brother / Sister		Uncle/ Aunt		
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marital Status? _____			
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of children, if any _____			
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What is your occupation? _____			
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use recreational drugs? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Blocked Arteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, what kind ? _____			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many drinks per wk? <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>			
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aerobic exercise (hours per wk) <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr><tr><td> </td></tr></table>			
Blood disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight training (hours per wk) <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr></table>			
Osteoporosis/penia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please describe: _____			
Other Cancers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take time for any hobbies? If so, which ones? _____			
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			

### 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

### Current Medications

	<u>Name</u>	<u>Dose per day</u>
1		
2		
3		
4		
5		
6		
7		

### Current Nutritional Supplements and/or Herbs

	<u>Name</u>	<u>Dose per day</u>
1		
2		
3		
4		
5		
6		
7		

## Medical History

(Past and Present - Check all that apply)

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

## 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)? \_\_\_\_\_

## Hormone Analysis (Men Only)

**Key: 1= Mild (occurs monthly), 2 = Moderate (occurs weekly), 3= Severe (occurs daily)**

Leave blank if symptom does not occur

Date of last PSA: \_\_\_\_\_ Date of last prostate exam: \_\_\_\_\_

Thinning of hair on beard	
Thinning of hair on body	
Reduced libido	
Disturbed sleep	
Depression	
Prostate enlargement/cancer	
Muscle weakness	
Fatigue	
Irritability	
Impotence	

Poor concentration/memory loss	
Abdominal weight gain	
Lost of interest in surroundings	
Night sweats	
Palpitations	
Insomnia	
Thinning skin	
Slow wound healing	
Anxiety	
Baldness/Balding	

# 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 water do you drink per day? ..... \_\_\_\_\_

Please indicate how often you eat the following foods per week. Refer to the key.

Food	Frequency
<b><i>Dairy</i></b>	
Milk	
Cheese	
Eggs	
Ice Cream	
Yogurt	
<b><i>Whole grains</i></b>	
Whole grain bread	
Whole grain pasta	
Brown rice	
Oatmeal	
Millet/Barley	
<b><i>Refined sweets/White flour</i></b>	
Donuts / Cakes	
Bagels	
Candy / Chocolates	
White Bread / Rice	
White pasta	
Cookies	
<b><i>Meat</i></b>	
Beef	
Tuna fish	
Pork	
Chicken	
Turkey	
Salmon	
<b><i>Legumes</i></b>	
Beans	
Peas	
Lentils	
<b><i>Beverages</i></b>	
Coffee	
Soft Drinks	
Black Tea	
Green Tea	
Fresh Juice	
Store Bought Juice	
<b><i>Fresh Fruits</i></b>	
<b><i>Vegetables</i></b>	
<b><i>Soy Protein</i></b>	
<b><i>Nuts and Seeds</i></b>	

**Key:**

- 0 = Rare (0-1 servings/week)
- 1 = Infrequent (2-3 servings/week)
- 2 = Moderate (4-6 servings/week)
- 3 = Frequent (>6 servings/week)

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

1 \_\_\_\_\_  
 2 \_\_\_\_\_  
 3 \_\_\_\_\_  
 4 \_\_\_\_\_  
 5 \_\_\_\_\_

## Endocrine Questionnaire

**Key:** 1= Mild (occurs monthly), 2 = Moderate (occurs weekly), 3= Severe (occurs daily)

Leave blank if symptom does not occur

Adrenal			
Decreased ability to handle stress			Headache if meals are skipped or delayed
Feel most energetic after dinner			Irritable or shaky if meals delayed
Difficulty waking up in the morning			Slow wound healing
Headache/fatigue after exercising			"Nervous" stomach
Chronic low back pain, worse with fatigue			Poor blood circulation in heart or arteries
Become dizzy when stand up suddenly			Inflammation
Difficulty with manipulative correction			Feeling wired or anxious
Arthritic tendencies			Type A personality
Crave salty foods			Wound up yet run down
Perspire easily			Stressed and fatigued/sleep easily
Increased efforts to do daily tasks			Stressed and sleep deprived
Continuing fatigue not relieved by sleep			Exhaustion, insomnia, mild depression
Lack of energy			Very sensitive to environmental pollutants
Poor physical stamina, strength, & endurance			Autoimmune conditions
Decreased mental focus or clarity			Migraines/headaches
Mental Fatigue			Get sick easily
Feeling depressed or low for no reason			Irritable
Lack of motivation			Weight gain around waist
Crave sweets or carbs			High blood pressure
Crave coffee or sugar in the afternoon			Insulin resistance
Fatigue relieved by eating			Impaired memory
			Loss of scalp hair

Low Thyroid			
Difficulty losing weight			Chronic constipation
Mentally sluggish/Reduced initiative			Excessive hair loss or course hair
Easily Fatigued/ Sleepy during the day			Morning headaches, wear off during day
Sensitive to cold/ poor circulation			Seasonal sadness

High Thyroid			
Trouble gaining weight even with large appetite			Flush easily
Nervous, emotional, can't work under pressure			Fast pulse at rest
Inward trembling			Intolerance to heat

# Hormone Analysis (Women Only)

**Key:** 1= Mild (occurs monthly), 2 = Moderate (occurs weekly), 3= Severe (occurs daily)

Leave blank if symptom does not occur

Estrogens low	
Hot flashes	
Night sweats	
Vaginal dryness	
Scanty or no menses	
Incontinence	
Depressed / Tearful	
Disturbed sleep	
Bone loss	
Foggy thinking / Memory lapse	
Hair loss	

Testosterone/DHEA low	
Depression	
Fatigue	
Decreased sex drive	
Decreased muscle mass	
Muscle aches / stiffness	
Bone loss	
Joint aches/pains	
Water retention	
Reduced sexual performance	

High Estrogen or Low Progesterone	
Mood swings	
Breast tenderness	
Water retention	
Foggy thinking	
Irritability	
Anxiety	
Fibrocystic breasts	
Weight gain- hips	
Heavy periods and/or clots	
Headaches	
Uterine fibroids	
Fatigue	
Cold body temperature	

Testosterone/DHEA high	
Weight gain	
Insulin resistance	
Loss of scalp hair	
Polycystic ovaries	
Irritability	
Acne	
Oily skin	
Excess facial/body hair	
Sore nipples	

Progesterone High	
Drowsiness	
Breast swelling	
Nausea	
Depression	
Foggy thinking	
Oily skin	
Increased acne	
Excess facial hair	

# Nutritional Questionnaire

**Key:** 1= Mild (occurs monthly), 2 = Moderate (occurs weekly), 3= Severe (occurs daily)

Leave blank if symptom does not occur

<b>Liver and Gall Bladder</b>			
Sweat has a strong odor			Light or clay colored stools
Food allergies/sensitivities			Dry skin, itchy feet, or skin peels on feet
Anus itches			Headache over eyes
Stools hard or difficult to pass			Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)
Excessive foul smelling lower bowel gas			Become sick if drink wine(0=no, 1=yes)
Stomach upset by greasy foods			Sensitive to chemicals(0=no, 1=yes)
Greasy or shiny stools			Hemorrhoids or varicose veins
Nausea			

<b>Digestive System</b>			
Bad breath(halitosis)			Food allergies/sensitivities
Sweat has a strong odor			Sinus congestion, "stuffy head"
Excessive foul smelling lower bowel gas			Airborne allergies
Undigested food in stools			Taken antibiotic for total accumulated time of (0=never, 1=<1 month, 2=<3 month, 3=>3 mon)
Sense of excess fullness after meals			Fungus or yeast infections
Bloating within 1 hour of eating			Heartburn or acid reflux
Are you a vegan?			Feel better if you don't eat
Loss of taste for meat			Stools hard or difficult to pass
Stomach upset by taking vitamins			Anus itches
Bloating/gas/belching 1 to 2 hours after eating			
History of parasites(0=no, 1=yes)			

<b>Mineral Needs</b>			
Carpal tunnel syndrome(0=no, 1=yes)			History of bone spurs
History of lower right abdominal pains (0 = No, 1 = Yes)			Morning stiffness
History of stress fracture(0=no, 1=yes)			Nausea with vomiting
Bone loss (reduced density on bone scan)			Crave chocolate
Are you shorter than you used to be? (0 = No, 1 = Yes)			Feet have a strong odor
Calf, foot, or toe cramps at rest			History of anemia
Cold sores, fever blisters, or herpes lesions			Whites of eyes(sclera) blue tinted
Frequent fevers			Hoarseness
Frequent skin rashes and/or hives			Difficulty swallowing
Herniated disc(0=no, 1=yes)			Lump in throat
Excessively flexible joints, "double jointed"			Dry mouth, eyes, and/or nose
Joints pop or click			Gag easily
Pain or swelling in joints			White spots on fingernails
Bursitis or tendonitis			Cuts heal slowly and/or scar easily
			Decreased sense of taste or smell

### Vitamin Need

Muscles become easily fatigued		Can hear heart beat on pillow at night	
Feel exhausted or sore after moderate exercise		Whole body or limb jerk as falling asleep	
Vulnerable to insect bites		Night sweats	
Loss of muscle tone, heaviness in arms/legs		Restless leg syndrome	
Enlarged heart or congestive heart failure		Cracks at corner of mouth(Cheilosis)	
Pulse below 65 per minute(0=no, 1=yes)		Fragile skin, easily chaffed, as in shaving	
Ringing in the ears(tinnitus)		Polyps or warts	
Numbness, tingling, or itching in hands/feet		MSG sensitivity	
Depressed		Wake up without remembering dreams	
Fear or impending doom		Small bumps on back of arms	
Worrier, apprehensive, anxious		Strong light at night irritates eyes	
Nervous or agitated		Nosebleeds and/or tend to bruise easily	
Feelings of insecurity		Bleeding gums especially when brushing teeth	
Heart races			

### Cardiovascular System

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                                    | <input type="checkbox"/> |
| 2 Women: above age 65                                  | <input type="checkbox"/> |
| 3 History of Heart or Arterial Disease                 | <input type="checkbox"/> |
| 4 History of Diabetes Mellitus                         | <input type="checkbox"/> |
| 5 Smoker   | <input type="checkbox"/> |
| 6 Sedentary lifestyle/ Obesity                         | <input type="checkbox"/> |
| 7 High Blood Pressure                                  | <input type="checkbox"/> |
| 8 Father had history of heart disease at 55 or younger | <input type="checkbox"/> |
| 9 Mother had history of heart disease at 65 or below   | <input type="checkbox"/> |

### 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 \_\_\_\_\_