Name:		Date:			
Address:		Unit:			
City:		State:		Zip:	
PHONE Home:		Mobile:		Work:	
Email Address:					

Date of Birth:		Gender:	☐ Male ☐ Female

Age:		Height:		Weight:	

Status:

☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Single
☐ Partnership

Live with:

☐ Spouse
☐ Partner
☐ Parents
☐ Children
☐ Friends
☐ Alone

Education:

Occupation: Hours per week: ☐ Retired

Employer Work Address

Please provide your insurance information:	Insurance Company:
	Policy Number:
Primary Cardholder and DOB:	

In case of emergency, whom should we contact?

Name	Relationship	Address	Phone

What help would you like from Dr. Ferguson?

WHY DO YOU WANT THIS HELP?

What is your major complaint? Please list when each symptom began and be as descriptive as possible:

What are your current medications?

What are your current vitamins and/or supplements?

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.):

Is there anything else in your medical history that you consider to be relevant? (Even from childhood)

What is your employment history? Please provide brief summary including dates if possible.

Please list your past or present Hobbies that could be sources of toxicity or chemicals:

How often are you involved in these Hobbies currently?

Please list past or present allergies, including allergies to medications.

Please list all past surgeries and the condition each surgery was for, including dates.

Please explain your housing history (type of homes, where and when).

Patient History

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

Mercury

☐ Yes	☐ No	Do you have amalgam (silver) fillings in your teeth? If so, How many? _____
☐ Yes	☐ No	Have you ever had an amalgam removed? If Yes, How many_____ Date? _____
☐ Yes	☐ No	If you had amalgams removed, was it done by a biological dentist using a safe protocol?
☐ Yes	☐ No	Did your mother have amalgam when pregnant with you?
☐ Yes	☐ No	Have you ever worked in a dental office? If so, how long? _____
☐ Yes	☐ No	Have you had any dental crowns? If yes, how many_____
☐ Yes	☐ No	Have you had any bridges?
☐ Yes	☐ No	Have you had any root canals?
☐ Yes	☐ No	Have you had any tooth extractions?
☐ Yes	☐ No	Do you have any dental implants, retainers or other metal in your mouth? Explain:_____
☐ Yes	☐ No	Did you wear contact lenses during the 1980's or early 1990's?
☐ Yes	☐ No	Did you take oral contraceptives during the 1980's or early 1990's?
☐ Yes	☐ No	Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
☐ Yes	☐ No	Have you noticed any adverse reactions to these shots?
☐ Yes	☐ No	Do you have any tattoos with red ink?
☐ Yes	☐ No	Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

Lead

☐ Yes	☐ No	Does your occupation involve soldering or metal salvage?
☐ Yes	☐ No	Have you done any old home repair or sandblasting? If so, When_____
☐ Yes	☐ No	Do you do a lot of painting?
☐ Yes	☐ No	Was your home built before 1978?
☐ Yes	☐ No	Have you ever worn cosmetics containing kohl? (make-up with dark black or deep red pigment)
☐ Yes	☐ No	Are you around a lot of fake leather, or vinyl?
☐ Yes	☐ No	Do you get stomach aches in the morning?

Yes	No	Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.
Yes	No	Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)
Yes	No	Do you have your house sprayed with pesticides for pest control?
Yes	No	Do you spray herbicide (weed killers) in or around your home?
Yes	No	Do you use conventional insect repellants on your self or family?
Yes	No	Do you use conventional sunscreen?
Yes	No	Do you use conventional perfume or cologne every day?
Yes	No	Do you get your hair colored? If so, is it on the scalp?
Yes	No	Do you use aerosol hairspray?
Yes	No	Do you get your nails done? If so, how often? _____
Yes	No	Do you use air freshener in your house, work or car?
Yes	No	Do you drink filtered water? If so, what type of filter do you have?_____
Yes	No	Do you drink bottle water if so what kind?
Yes	No	Do you have a water filtration system for your entire house or shower filtration? If so, what type?_____
Yes	No	Does your spouse or other family members work around chemicals?
Yes	No	Can you think of any other toxic exposures you may have had?

Mold

How old is the house you are living in? _____ How long have you lived there? _____

Have you noticed any new symptoms since moving in?_____ If so, what?_____

Yes	No	Do you see mold growing at home, work or school?
Yes	No	Have you ever had water damage at home, work or school?
Yes	No	Does your home, workplace or school have a damp or mildew smell?
Yes	No	Does spending time in your basement cause or worsen your symptoms?
Yes	No	Does your basement ever get wet?
Yes	No	Do you have a crawl space?
Yes	No	Does your basement or crawl space have a sump pump?
Yes	No	Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?
Yes	No	Does your car have a mildew smell?
Yes	No	Does anyone in your home have asthma like symptoms?
Yes	No	Does anyone in your family have chronic sinus infections or irritations?

Lyme Disease

Yes	No	Have you ever been diagnosed with Lyme Disease?
Yes	No	Have you had dry sockets or infected tooth extractions?
Yes	No	Do you have small joint pain?
Yes	No	Have you ever been bitten by a tick or recluse spider?
Yes	No	Have you ever seen a bulls-eye rash appear on any part of your body?
Yes	No	Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?
Yes	No	Was your mother ever diagnosed with Lyme Disease?
Yes	No	Have you ever been diagnosed with Chronic Fatigues Syndrome, Fibromyalgia, Lupus, Rheumatoid Arthritis (RA), Multiple Sclerosis (MS), or an Autoimmune condition?

☐ Yes ☐ No Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

Health History

☐ Yes ☐ No Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?

☐ Yes ☐ No Does anyone in your family experience similar symptoms to yours?

What is your birth order (i.e. first born, second, third, etc.)? _____.

☐ Yes ☐ No Do you have any history of kidney dysfunction?

☐ Yes ☐ No Do you or any immediate family member have a history with cancer?

☐ Yes ☐ No Do you have any history of heart disease, myocardial infarction (heart attack), etc.?

☐ Yes ☐ No Are you currently having any thoughts of suicide?

☐ Yes ☐ No Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?

☐ Yes ☐ No Do you have a history of strokes?

☐ Yes ☐ No Have you ever been diagnosed with diabetes, thyroiditis, or heart disease?

☐ Yes ☐ No Have you ever been in an auto accident, fallen or received a major physical injury?

☐ Yes ☐ No Are you in menopause?

Microbiome Health

☐ Yes ☐ No Do you get distention, bloating, feeling full and a noisy gut after eating healthy carbohydrates such as broccoli, Brussels sprouts or other vegetables?

☐ Yes ☐ No Do you often have gas that has a sulfur or foul smell?

☐ Yes ☐ No Are you sensitive to supplements?

☐ Yes ☐ No Have you ever been vegan or vegetarian for any length of time?

☐ Yes ☐ No Can you tolerate Meat?

☐ Yes ☐ No Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?

☐ Yes ☐ No Have you taken birth control or Hormone replacement therapy for any length of time?

☐ Yes ☐ No If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?

☐ Yes ☐ No Have been on antibiotics for any extended period of time or often as a child or adult?

☐ Yes ☐ No Were you caesarian delivered?

☐ Yes ☐ No Were you breast fed? If so, How long _____

☐ Yes ☐ No Does your gut temporarily feel better after a round of antibiotics?

How many times a day are you having a bowel movement? _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

0 = Never had the symptom
1 = Occasionally have it, mild effect
2 = Occasionally have it, severe effect
3 = Frequently have it, mild effect
4 = Frequently have it, severe effect

Column #1		Column #2	
	Anxiety		Sensitivity to light
	Mood swings		Fatigue after exercising (feeling worse)
	Enraged behavior or anger for no reason		Bad night vision or seeing halos around lights
	Excessive shyness, timidity, social phobia (not typical to your personality)		Shortness of breath, with very little effort
	Irritability (not typical to your personality)		Excessive thirst and/or frequent urination
	Low body temperature (below 97.5°)		Red eyes or tearing
	Insomnia (can't get to sleep or return to sleep		Blurred vision at times
	Dizziness		Morning stiffness
	Sound in ears (ringing or hearing your heart beat)		Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Psychological symptoms, even thoughts of suicide		Chronic fatigue or weakness
	Sensitivity to sound		Non-restful sleep
	Indecisiveness		Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
	Feeling of being overwhelmed or fearful		Trouble processing new information
	Metallic taste in your mouth		Word reversal or trouble finding words
	Bad breath		Sensitivity to touch
	Bleeding gums		Short-term memory loss
	Sensitive teeth		Chronic sinus congestion
	Canker sores or other sores in the mouth		Dry non-productive cough
	Floaters, shadows or swimmers when you read or look into the sky		Muscle twitching
	Dyslexia or loss of place while reading, even as a child		Excessive sweating, especially at night
	Swelling eyelids		Joint pain-not necessarily true arthritis-can move from joint to joint
	Peeling on top layer of skin (hands, feet)		Difficulty losing weight regardless of diet or exercise
	Dry skin		Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
	Heart pain (angina) and you are under 45 years old		Frequent illness, prolonged illness or sick days
	Depression		Numbness or weakness in arms and legs
	Gout (arthritic pain, especially in big toes)		Headaches
	Pain in shoulders or upper back		Trouble adding or dividing numbers in your head
	Twitching eyelids		Fluctuating constipation and diarrhea
	Anemia (low iron/hemoglobin on blood test)		Stomach pain for no apparent reason
	Wrist/ankle drop or weak extensor muscles		Appetite swings
	Hair falls out (not normal male pattern baldness)		Frequent muscle aches, cramps, unusual sharp sudden pains
			Rashes or rosacea
			Cold extremities (hands and feet)

	Total Columns 1 & 2