



# LifeXtra Questionnaire

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## STEP TWO / THREE

**2. Patient Information Summary** helps you and CHIPSA begin a pre-authorized patient summary and review of your health history.

**3. Treatment Preference and Criteria** asks you to identify 'health preferences' and treatment as you determine the 'how and why' to assess your treatment and our medical facility in the confidence of your trust in medical care.

These steps ask to identify decision-lifestyle influencers (such as; dental, allergies, diet, herbal supplements, etc.) and points to any additional family information you may have encountered during your search for the best medical care.

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### The following is covered:

DECISION SENSITIVITY  
HEALTHCARE PREFERENCE

EXPOSURE  
DENTAL HISTORY  
FOOD ISSUES / SENSITIVITIES  
FAMILY HISTORY  
SOCIAL HISTORY

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## DECISION SENSITIVITY

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**Criteria Emphasis** (please choose either)

- |   |   |
|---|---|
| 1. <input type="checkbox"/> doctor's medical experience | <input type="checkbox"/> quality of medical facility        |
| 2. <input type="checkbox"/> comfort of treatment        | <input type="checkbox"/> aggressive treatment               |
| 3. <input type="checkbox"/> cost of care                | <input type="checkbox"/> quality of care (positive results) |
| 4. <input type="checkbox"/> patient testimonial         | <input type="checkbox"/> a doctor's referral                |

## HEALTHCARE PREFERENCE

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Please mark **ALL** that interest you as you consider health care

### Traditional Western Medicine

- Chemotherapy     Surgery     Pharmaceutical     Radiation

### Complementary Alternative Medicine (CAM)

- Ayurvedic 'Mind-Body' Medicine     Chinese Acupuncture     Biofeedback  
 Herbal Medicine     Chiropractic     Energy Medicine     Homeopathy  
 Naturopathy     Tibetan Medicine

### Integrative Medicine - New

- Immunonutrition Therapy     Immunotherapy     Vitamin Supplement Therapy  
 Stem Cell Therapy     Growth Hormone Therapy     Herbal Therapy

**Why CHIPSA Medical?** \_\_\_\_\_

\_\_\_\_\_

**COMMENTS:** Let us know what your first thoughts while locating a medical care facility.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EXPOSURE:**

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**Have you been exposed to any of the following?**

**Agricultural chemicals:**  Yes  No

If yes, please list below: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Industrial /Workplace chemicals:**  Yes  No If yes, please list below: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Cigarette smoking:**  Yes  No If yes, how much and how long? \_\_\_\_\_

When last cigarette smoked? \_\_\_\_\_

**Second hand smoke?**  Yes  No If yes, how much? \_\_\_\_\_

**Alcohol use?**  Yes  No How much? \_\_\_\_\_

**Past Occupations:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DENTAL HISTORY:**

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**Do you have silver-mercury fillings?**  Yes  No If yes, how many? \_\_\_\_\_

**Do you have root canals?**  Yes  No If yes, how many? \_\_\_\_\_

**Have you been tested for having metal toxicity?**  Yes  No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOOD ISSUES / SENSITIVITIES:**

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**Do you have any food allergies?**  Yes  No If yes, please list below:

**Do any foods give you significant gas, pain, or bloating?**  Yes  No

If yes, please list \_\_\_\_\_  
\_\_\_\_\_

**Any tattoos or piercings?**  Yes  No If yes, when and where? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please describe your diet** (e.g., fresh organic vegetables and fruit, juicing, restaurants 3 times per week, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Stomach Disorders or General Digestion Problems**

Acid Indigestion:  No  Yes, in the past /  Yes, currently \_\_\_\_\_

Acid Reflux:  No  Yes, in the past /  Yes, currently \_\_\_\_\_

Bloating/Flatulence:  No  Yes, in the past /  Yes, currently \_\_\_\_\_

Colitis:  No  Yes, in the past /  Yes, currently \_\_\_\_\_

Constipation:  No  Yes, in the past /  Yes, currently \_\_\_\_\_

Diarrhea:  No  Yes, in the past /  Yes, currently \_\_\_\_\_

Diverticulitis:  No  Yes, in the past /  Yes, currently \_\_\_\_\_

Hiatal Hernia:  No  Yes, in the past /  Yes, currently \_\_\_\_\_

Irritable Bowel:  No  Yes, in the past /  Yes, currently \_\_\_\_\_

Ulcers:  No  Yes, in the past /  Yes, currently \_\_\_\_\_

**Please list any supplements, vitamins, or herbs you are taking, including:**

	<b>Dosage</b>	<b>Date beginning</b>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

**When you started taking:**

**FAMILY HISTORY:**

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**Mother:**       Alive     Deceased

**Father:**       Alive     Deceased

**Sisters:**     Number Alive \_\_\_\_\_ Number Deceased \_\_\_\_\_

**Brothers:**    Number Alive \_\_\_\_\_ Number Deceased \_\_\_\_\_

**Please insert the name of the family member wherever it may apply below.**

Include parents, brothers-sisters, aunts-uncles, grandparents and children.

High Blood Pressure:  No     Yes, in the past /  Yes, currently \_\_\_\_\_

Heart Disease:         No     Yes, in the past /  Yes, currently \_\_\_\_\_

Stroke-Thrombosis:  No     Yes, in the past /  Yes, currently \_\_\_\_\_

Diabetes:               No     Yes, in the past /  Yes, currently \_\_\_\_\_

Arthritis:               No     Yes, in the past /  Yes, currently \_\_\_\_\_

Liver/Gall Bladder:  No     Yes, in the past /  Yes, currently \_\_\_\_\_

Lung Disease:          No     Yes, in the past /  Yes, currently \_\_\_\_\_

Asthma:                 No     Yes, in the past /  Yes, currently \_\_\_\_\_

Emphysema:           No     Yes, in the past /  Yes, currently \_\_\_\_\_

Kidney Disease:       No     Yes, in the past /  Yes, currently \_\_\_\_\_

Seizure Disorder:     No     Yes, in the past /  Yes, currently \_\_\_\_\_

Auto-immune:          No     Yes, in the past /  Yes, currently \_\_\_\_\_

Rheumatoid Arthritis:  No     Yes, in the past /  Yes, currently \_\_\_\_\_

SLE (Lupus):          No     Yes, in the past /  Yes, currently \_\_\_\_\_

Celiac:                 No     Yes, in the past /  Yes, currently \_\_\_\_\_

Chrons:                 No     Yes, in the past /  Yes, currently \_\_\_\_\_

Hyperthyroidism:     No     Yes, in the past /  Yes, currently \_\_\_\_\_

Hypothyroidism:      No     Yes, in the past /  Yes, currently \_\_\_\_\_

Multiple Sclerosis:  No     Yes, in the past /  Yes, currently \_\_\_\_\_

Mental Depression:  No     Yes, in the past /  Yes, currently \_\_\_\_\_

**Cancer:**

Type \_\_\_\_\_ Relative \_\_\_\_\_

Type \_\_\_\_\_ Relative \_\_\_\_\_

Type \_\_\_\_\_ Relative \_\_\_\_\_

Type \_\_\_\_\_ Relative \_\_\_\_\_

Type \_\_\_\_\_ Relative \_\_\_\_\_

Type \_\_\_\_\_ Relative \_\_\_\_\_

Type \_\_\_\_\_ Relative \_\_\_\_\_

**Other:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Contact Information

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Feel free to call Patient Services at our main office number: (877) 424-4772

Patient Services is open Monday through Friday from 7:30 until 4 PM.

We will always be closed on holidays and every weekend. Our phones are connected to voicemail that will answer phones if we are not available. Please leave us a message and we will get back to you as soon as we can.

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## CHIPSA

### **Gerson Medical Center**

670 Colonia Jardines del Sol  
Playas Tijuana, Mexico, C.P. 22700

### **CHIPSA US-Mail**

PO Box 1850, Chula Vista, CA 91912

patientservices@chipsa.com  
lifeline@chipsa.com  
admissions@chipsa.com

<http://www.chipsa.com>

CHIPSA Hospital: **011-52 (664) 680-2902**

CHIPSA FAX: **011-52 (664) 680-2908**

Patient Services: **(877) 424-4772**

Information Services: (800) 759-2966

**FOR ANY LOCAL EMERGENCY CONTACT YOUR PHYSICIAN,  
GO TO YOUR LOCAL EMERGENCY ROOM OR CALL 911.**

If you need to contact us in an emergency, call the main hospital number at (877) 424-4772 and ask for the Patient Services. Explain to the representative that you have an emergency and ask to have the Resident on-call paged or called.



## CHIPSA

CENTRO HOSPITALARIO INTERNACIONAL PACIFICO, SA

**Gerson Medical Center**

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