Winter Wellness

NEW PATIENT INTAKE FORM

Successful healthcare and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this overview will greatly aid us in assisting to your health needs.

Personal Details

Name		DOB		Birth Sex	Female Male Unknown	Gender Identity	
Email				Phone			
Address		City, State, ZIP					
Emergency Contact Name and Phone							

Allergies

Medication/Drug Allergies	
Food Allergies	
Environmental Allergies	

Medications/Supplements

Medications	
Supplements	

General Health History:

List of health concerns, in order of importance					
Previous surgeries and hospitalizations, with dates					
Height		Current Weight		Ideal weight	
Maximum weight as an adult		Minimum weight as an adult			
How often do you exercise? What kinds of exercises do you do?					
How much sleep do you get? Do you wake up feeling refreshed? Do you have trouble falling or staying asleep?					

Please list the date of your last

	Date:		Date:		Date:
Bloodwork		Chest x-ray		Pap smear	
Dental Exam		Colonoscopy		Mammogram	
Eye exam		Bone scan			
Other Imaging (please list):					

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Family History: Please check any illnesses/conditions immediate family has had (grandparents, parents, siblings, children).

High Blood Pressure	☐	DVT	☐	Lung Disease	☐	Stroke	☐
High Cholesterol	☐	Pulmonary Embolism	☐	Asthma	☐	Diabetes	☐
Vein Trouble	☐	Tuberculosis	☐	Heart Trouble	☐	Pneumonia	☐
Kidney Disease	☐	Nervous Disorder	☐	Seasonal Allergies	☐	HIV	☐
Liver Disease	☐	Seizures	☐	Eye Problems	☐	Sinus	☐
Drug Abuse/Alcoholism	☐	Thyroid Problems	☐	Arthritis	☐	Tonsilitis	☐
Joint Replacement	☐	Hepatitis	☐	Gastrointestinal	☐	Osteoporosis	☐
Cancer	☐	Bleeding Tendencies	☐				

Which of the following do you use?

	Yes	No	In the Past		Yes	No	In the Past
Antacids	☐	☐	☐	Alcohol If "yes" or "in the past", how much?	☐	☐	☐
Analgesics	☐	☐	☐				
Laxatives	☐	☐	☐	Soda If "yes" or "in the past", how much?	☐	☐	☐
Steroids	☐	☐	☐				
Smoking If "yes" or "in the past", how many packs per day and for how many years?	☐	☐	☐	Recreational drugs	☐	☐	☐
				Addictions and/or treatment for addictions	☐	☐	☐
Coffee If "yes" or "in the past", how many cups per day?	☐	☐	☐	If "yes" or "in the past", please explain.			

Social Life

What is your occupation? Do you enjoy it?		What are your hobbies?	
What is your relationship status?		Are you satisfied with you Significant Relationship?	
Do you have history of mental, physical or emotional abuse?			
	Please list your typical		
Diet	Breakfast:	Lunch:	Dinner:
Gluten-free Vegan Paleo Raw AIP Diet Vegetarian Organic Ketogenic Low FODMAP Other:	Snacks:	Beverages:	

Review of Systems

Skin	Rash Psoriasis Cancer Color changes Dryness/Itchiness Hives Eczema Warts Abnormal mole	Respiratory	Asthma Pneumonia TB Shortness of breath Pain with breathing Emphysema Cough Bronchitis Wheezing	Gastrointestinal	Heartburn Gas/bloating Diarrhea Ulcers Liver disease Change in appetite Pancreatitis Urgency Pain with urination Indigestion Constipation Vomiting Hemorrhoids Nausea Gallbladder disease Stomach pain
Head	Migraines Dandruff Oily/Dry hair Headaches Hair loss Head injury				
Nose	Nosebleeds Allergies Frequent colds Polyps Congestion Problems smelling	Cardiovascular	Palpitations Murmur Rheumatic fever High blood pressure Low blood pressure Chest pain Heart attack Edema Arrhythmia	Number of bowel movements per day/week?	
				Mental/Emotional	Depression Eating disorder Fear/panic Psychiatric hospitalization Obsessive Anxiety Suicidal thoughts Irritability Bipolar
Eyes	Dryness Redness Glaucoma Pain Vision problems Itchiness Cataracts Styes Watery/discharge	Urinary Tract	Incontinence Kidney stones Frequent infections Urgency Blood in urine Pain with urination	Nervous System	Paralysis Sciatica Seizures Fainting Numbness/tingling Carpal tunnel
Mouth/Throat/Neck	Cavities Sores Goiter Sore throat Problems speaking Problems swallowing Dentures Neck stiffness Gum disease Swollen glands Problems tasting	Musculoskeletal	Weakness Tremors Leg cramps Stiffness Arthritis Pain		

Males

STDs	Erectile dysfunction	Hernia
Pain	Frequent nighttime urination	Sexually active
Prostate disease	Discharge	Testicular pain/swelling

Females

Abnormal Pap	Pain with intercourse	Odor
STDs	Sexually active	Vaginal dryness
Discharge	PMS	Healthy libido
Heavy bleeding	Vaginitis	Menstrual cramping

Age of first menses		First day of last menses		Average length of menses	
Birth control methods, either previously or currently used					
Times pregnant		Age of menopause		Number of children	
Number of miscarriages		Number of abortions			

Thank you for taking the time to fill out this form.
We look forward to meeting you!