New Patient Adult Intake

Desert Foothills Concierge Medicine

How did you hear about us (please be specific)?

Reason for office visit:

Context of Care Review

Successful heath care and preventive medicine are only possible when the provider has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your healthcare goals. Your time and honesty in completing this overview will help me to help you meet those goals.

Why did you choose to come to this clinic?

What expectations do you have from me?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are less beneficial to a healthy lifestyle?

What potential obstacles do you foresee in addressing the lifestyle factors which are preventing you from leading a healthy lifestyle?

What do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

How often do you do these things?

Current Living Situation

Highest Education Level: _____

Occupational status: ☐ Working Full/Part Time ☐ Retired ☐ Disabled

Marital status: ☐ Single ☐ Married ☐ Long-Term Relationship ☐ Divorced ☐ Widowed

Name of Spouse/Significant Other: _____

Years married: _____

Spouse's/SO present health: _____

Total number of children: _____

How is your overall relationship with your children? (None, Distant, Conflicted, Warm or Very Close)

Have you served in the military? ☐ Yes ☐ No

If yes (Thank You), please specify what branch and when?

Childhood/Family History

List any significant accidents, illnesses, or injuries that occurred during your childhood:

Father

If living: age and health:

If deceased: age, year, and cause of death:

Mother

If living: age and health:

If deceased: age, year, and cause of death:

How is your relationship with your parents and siblings? (None, Distant, Conflicted, Warm or Very Close):

Personal HIstory

Are you currently receiving healthcare? ☐ Yes ☐ No

If yes, where and from whom?

If no, when and where did you last receive healthcare?

Current Chronic Health Conditions:

☐ Hypertension	☐ Diabetes	☐ Obesity
☐ Cardiovascular Disease	☐ Autoimmune/Autoinflammatory Disorder	☐ Hashimoto's
		☐ Hyper/Hypo Thyroid
☐ Psoriasis	☐ IBS/Crohn's	☐ Ulcerative Colitis
☐ Celiac Disease	☐ GERD	☐ Lupus
☐ Rheumatoid Arthritis	☐ Multiple Sclerosis	☐ ALS
	☐ Cancer	☐ Stroke
☐ Metabolic Syndrome	☐ Chronic Pain	☐ Fibromyalgia
	☐ Herpes	☐ Vertigo
☐ Asthma/Bronchitis	☐ Parkinson's Disease	

How long have you been dealing with these medical problems?

Are you being treated for this problem? ☐ Yes ☐ No

List any accidents, illnesses injuries, hospitalizations/surgeries or imaging (X-ray, CAT scan, MRI etc) related to these problems:

General

Height: _____

Weight: _____

Main interests and hobbies:

Do you use any illegal drugs including marijuana? ☐ Yes ☐ No

If yes, what and how often?

Have you ever been in treatment for alcohol or drug use? ☐ Yes ☐ No

If yes, please explain:

Do you use tobacco? ☐ Yes ☐ No

If yes, how much?

Do you drink alcohol? ☐ Yes ☐ No

If yes, please specify: ☐ Rarely ☐ Occasionally ☐ Daily ☐ Past

How many drinks do you usually have? _____

Do you smoke?(if yes or inpast, specify how many times a day) ☐ Yes ☐ No ☐ In Past

Rate your stress level on a scale of 1-10 during the average week: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Current Medications and Supplements

Are you sensitive or allergic to any medications or foods?

Are you sensitive or allergic to any environmental chemicals?

List all medications (from drugstore or prescription) you are taking and dosages if known:

List all supplements and vitamins you are taking and dosages if known:

Extra Space for more:

Health History

Endocrine

Please assess your sleep habits and check all that apply:

☐ Wake up Tired ☐ Afternoon Fatigue ☐ Average 6-8 hours sleep per night
☐ Been told you snore ☐ Able to fall asleep ☐ Able to stay asleep
☐ Have Insomnia

Do you suffer from dizziness when standing up quickly? ☐ Yes ☐ No

Have you ever been diagnosed with Hyperthyroid/Hypothyroid? ☐ Yes ☐ No

Please list any medications or supplements?

Have you ever been told you have Hypoglycemia? ☐ Yes ☐ No

Do you have difficulty losing weight? ☐ Yes ☐ No

Do you suffer with thinning of hair on scalp, face, or genitals? ☐ Yes ☐ No

Neurologic

Please check any conditions you have experienced or been diagnosed with:

☐ Seizures ☐ Muscle Weakness ☐ Loss of Memory
☐ Vertigo/Dizziness ☐ Paralysis ☐ Numbness/Tingling
☐ Loss of Balance

If yes to any above, please explain:

Neck

Please think about these symptoms and check any that you might experience:

☐ Neck pain/stiffness ☐ Difficulty swallowing ☐ Lumps in your neck
☐ Goiter

If yes to any above, please explain:

Immune System

Have you experienced any of the following?

☐ Chronically swollen glands ☐ Slow healing wounds ☐ Chronic fatigue syndrome
☐ Chronic Infections ☐ Night Sweats

If yes to any above, please explain:

Ears

Have you noticed any of the following?

☐ Ringing in your Ears ☐ Earaches ☐ Impaired Hearing
☐ Excessive Wax

If yes to any above, please explain:

Eyes

Have you noticed or been diagnosed with any of the following?

☐ Impaired Vision ☐ Blindness ☐ Cataracts
☐ Glaucoma ☐ Excessive Tearing ☐ Dryness
☐ Color Blind ☐ Spots in Vision ☐ Eye Pain

If yes to any above, please explain:

Head

Do you ever experience any of the following?

☐ Headaches ☐ Migraines ☐ Head Injury
☐ Loss of Consciousness ☐ TMJ or Jaw Problems

If yes to any above, please explain

Nose and Sinus

Do you ever experience any of the following?

☐ Stuffiness ☐ Sinus Problems ☐ Nose Bleeds
☐ Nasal Polyps ☐ Hay Fever ☐ Other Allergies
☐ Loss of Smell

If yes to any above, please explain:

Mouth and Throat

Do you experience any of the following?

☐ Grinding Teeth ☐ Gum Problems ☐ Missing Teeth
☐ Jaw Clicks ☐ Sore Tongue or Lips ☐ Hoarseness

If yes to any above, please explain:

Skin

Do you ever experience any of the following?

- ☐ Eczema
- ☐ Hives
- ☐ Dry/Flaky Skin/Scalp
- ☐ Acne
- ☐ Boils
- ☐ Unexplained changes in skin color
- ☐ Lumps/Bumps on Skin
- ☐ Perpetual Hair Loss
- ☐ Weak Nails

If yes to any above, please explain:

Respiratory/Cardiac

Have you ever experienced any of the following?

- ☐ Shortness of Breath
- ☐ Shortness of Breath While Lying Down
- ☐ Pain while Breathing
- ☐ Chronic Cough
- ☐ Coughed up Blood
- ☐ Asthma
- ☐ Wheezing
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Heart Palpatations

If yes to any above, please explain:

Musculoskeletal

Do you ever suffer with any of the following?

- ☐ Muscle Spasms
- ☐ Muscle Cramps
- ☐ Arthritis
- ☐ Joint Pain/Stiffness
- ☐ Sciatica
- ☐ Weakness
- ☐ Broken Bones

If yes to any above, please explain:

Blood

Have you experienced or been diagnosed with any of the following?

- ☐ Varicose Veins
- ☐ Blood Clot
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Experience Cold Hands/Feet

If yes to any above, please explain:

Gastrointestinal

Do you ever:

- ☐ Crave Sweets
- ☐ Get Irritable if Meals are Missed
- ☐ Depend of Coffee to keep Going
- ☐ Get Lightheaded if Meals are Missed
- ☐ Find that Eating Relieves Fatigue
- ☐ Increase/Decrease in Thirst
- ☐ Change in Appetite
- ☐ Find that Greasy/High Fat Foods Cause Distress
- ☐ Experience Heartburn

If yes to any above, please explain:

Do you ever suffer from:

☐ Abdominal Pain/Cramps
☐ Excessive Belching, Burping, Bloating
☐ Experience Gas After Meals
☐ Noticed Offensive Breath

If yes to any above, please explain:

Do you ever use:

☐ Antacids
☐ Laxatives
☐ Stool Softeners
☐ Enema
☐ Anti-Diarrheal

Ever experience:

☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Alternating Diarrhea/Constipation

If yes to any above, please explain:

Ever been diagnosed with:

☐ Ulcers
☐ Gallbladder Disease
☐ Gallstones
☐ Liver Disease
☐ Pancreatitis

If yes to any above, please note when and if resolved:

Have you ever had your gallbladder removed?

☐ Yes ☐ No

If yes, when?

Do you have Hemorrhoids?

☐ Yes ☐ No ☐ In Past

Do you ever have Hard, dry, or small stool?

☐ Yes ☐ No ☐ In Past

Have you ever experienced Black stools?

☐ Yes ☐ No ☐ In Past

If yes, what did you do?

Have you ever noticed Blood in your stools?

☐ Yes ☐ No ☐ In Past

If yes, what did you do?

How often do you move your bowels? _____

What do you a consider a change in your bowel habits?

Mental/Emotional

Have you ever been treated for memory problems? ☐ Yes ☐ No ☐ In Past

Have you experienced a history of physical, mental or financial abuse? ☐ Yes ☐ No ☐ In Past

Do you ever suffer from Depression? ☐ Yes ☐ No ☐ In Past

If yes, How long do these periods of depression last?

Do you ever experience Anxiety or nervousness? ☐ Yes ☐ No ☐ In Past

Have you ever experienced poor concentration? ☐ Yes ☐ No ☐ In Past

Do you ever experience mood swings? ☐ Yes ☐ No ☐ In Past

Sexuality issues? ☐ Yes ☐ No ☐ In Past

Do you ever experience mental sluggishness? ☐ Yes ☐ No ☐ In Past

Adult Mental Health

Have you ever received mental health counseling? ☐ Yes ☐ No

If yes, please specify: ☐ Psychiatrist ☐ Psychologist ☐ Clergy

Was it helpful? ☐ Yes ☐ No

Have you ever had thoughts of, planned or attempted suicide? ☐ Yes ☐ No

If yes, please explain:

Are you currently having thoughts of harming yourself? ☐ Yes ☐ No

Are you currently having thoughts of harming someone else?

☐ Yes ☐ No

Please list any psychiatric medications you are taking along with dosages and reasons for taking:

Urinary

Do you ever experience any of the following?

☐ Increased Frequency of Urination (at Night?)
☐ Inability to Hold Urine
☐ Pain with Urination
☐ Frequent Urinary Infections
☐ Kidney Stones
☐ Blood in your Urine

If yes to any above, please explain:

Female Reproductive

Date of Last Pap:

Results

☐ Normal ☐ Abnormal

Are you menstruating?

☐ Yes ☐ No

If yes, check all that apply:

☐ Normal ☐ Clotting ☐ Scant Flow
☐ Heavy Flow ☐ Pain ☐ Irritable/Depressed

Are you sexually active?

☐ Yes ☐ No ☐ In Past

Do you experience any of the following?

☐ Pain with Intercourse
☐ Increased Sex Drive
☐ Decreased Sex Drive
☐ Vaginal Odor/Discharge

If yes to any above, please explain:

Birth control?

☐ Yes ☐ No ☐ In Past

Do you experience any of the following?

☐ Acne Breakouts ☐ Ovarian Cysts ☐ Hair Loss/Thinning
☐ Facial Hair Growth

If yes to any above, please explain:

History of STDs?

☐ Gonorrhea ☐ Chlamydia ☐ Herpes
☐ Genital Warts ☐ Syphilis

Pregnancies? ☐ Live ☐ Difficulty Conceiving ☐ Miscarriage ☐ Abortion

Please elaborate on any of the above:

Do you do self breast exams? ☐ Yes ☐ No ☐ In Past

Do you experience any of the following? (Check all that apply) ☐ Breast pain/tenderness ☐ Nipple discharge ☐ Lumps

Menopausal symptoms (pre/post)? ☐ Yes ☐ No

Are you taking hormone replacements? ☐ Yes ☐ No

Hysterectomy (when)? ☐ Yes ☐ No

Male Reproductive

Are you sexually active? ☐ Yes ☐ No ☐ In Past

Sexual orientation?

Experience any of the following? (Check all that apply) ☐ Increase sex drive ☐ Decrease sex drive ☐ Decrease in spontaneous morning erections ☐ Decrease in fullness of erections ☐ Premature ejaculation ☐ Impotence

History of STDs? ☐ Genital Warts ☐ Chlamydia/Gonorrhea ☐ Herpes ☐ Impotence ☐ Penile Discharge/Sores ☐ HIV

Do you perform testicular self-exam? ☐ Yes ☐ No

If yes, have you noted any of the following? ☐ Testicular Lumps ☐ Testicular Mass ☐ Testicular Pain ☐ Prostate Disease ☐ Hernias

If yes to any above, please explain: