Utah Natural Medicine

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PATIENT INTAKE

Patient Name: ______________________Date of Birth_______________ Today's Date:_____________

Please list in order of importance your chief medical complaints or problems:

1.____
2.____
3.____

Current Prescription Medications with dose:

________________________________ __________________________________
________________________________ __________________________________
________________________________ __________________________________

Recent [within past 6 months] Prescription Medications no longer taking:

________________________________ __________________________________
________________________________ __________________________________
________________________________ __________________________________

Current Non-Prescription Substances [Nutritional, herbal, over-the-counter meds.] with dose:

________________________________ __________________________________
________________________________ __________________________________
________________________________ __________________________________

If additional space is needed, please use the end of this form or backside.

Diet: Circle the foods you eat on a regular basis.

Tofu	Luncheon meats	Eggs	Fresh vegetables	Coffee/Tea
Beef	Milk: cow's, soy,	Frozen foods	Dark leafy	Herbal tea
Chicken	rice, almond	Fast foods	greens	Alcohol
Turkey	Cheese	Organic foods	Pasta	Sodas
Fish	Butter	Nuts & Seeds	Rice	Filtered water
Tuna fish	Margarine	Flax/Fish oil	Whole grains	Diet foods/plans
Pork		Fresh fruit	White flour	Artificial
			Refined sugar	sweetener

What describes your diet best? ____Omnivore (animal and plant based) ____ Vegetarian
____ Vegan _____ Low Fat _____ Low Salt ____ Low Carbohydrate

Specific restrictions: ____ Wheat or gluten ___ Dairy ___Soy ___Gluten __other ? ___________

Servings of fruits per day? ____________ Servings of vegetables per day? ____________

Family Medical History: Have any family members had any of the following (please indicate mother, father, brother, aunt, grandfather, etc. and whether on paternal or maternal side):

Diabetes ____________	High blood pressure ____________	Heart disease ____________
Cancer ____________	Bleeding disorder ____________	Epilepsy ____________
Asthma ____________	Thyroid disorder ____________	Gout ____________
Birth defects ____________	Kidney disease ____________	Mental illness ____________
Heart attack ____________	Stroke ____________	Tuberculosis ____________
Emphysema ____________	Alcoholism ____________	Substance abuse ____________
Osteoporosis ____________	Auto-Immune disease____________	Arthritis ____________

Patient Name: Date of Birth:

Your Medical History

Current Weight:______ Max. Weight:_______ Significant weight change in past six months?:_____

Please list major illnesses you have ever had: ____

____

Please list any major surgeries and/or hospitalizations you have ever had, include date:

____

____

Do you have any allergies to Medications? __No __Yes, please list: ________________________

____

Do you have any food allergies? __No __Yes, please list: _________________________________

Do you have Seasonal/Environmental allergies? __No __Yes, please list:

____

Have you ever been diagnosed/treated for psychological or emotional conditions? __No __Yes please specify with dates: ____

____

How would you rate your General Health? Excellent Good Fair Poor

Review of Systems: Please circle any of the following conditions/symptoms you have had in the past year:

- **Skin:**

Rashes
Itching
Burning
Warts
Hair Loss
Skin cancer
Dry skin
Brittle nails
Discoloration
Eczema
Psoriasis
Swellings or bumps

- **Head, Eyes, Ears, Nose, Throat:**

Headaches
Blurred vision
Partial/full loss vision
Eye pain
Chronic sinusitis
Mouth sores
Change/loss of taste
Thrush
Chronic cough
Chronic sore throat

- **Cardiovascular:**

Angina
Heart attack
Stroke
Valve disease
Chest pain
Palpitations
Fainting
Swollen Feet/ankles
Varicose veins

- **Pulmonary:**

Breathing difficulty
Shortness of breath
Asthma
Coughing up blood

- **Gastrointestinal:**

Abdominal pain
Chronic constipation
Chronic diarrhea
Nausea
Vomiting
Jaundice
Dark/bloody stools
Abnormal colonoscopy

- **Genitourinary:**

Pain/burning urination
Blood in urine
Frequent urination
Urgent need to urinate
Kidney stones
Flank or kidney pain
Sexually transmitted diseases
Problems with sexual function

- **Musculoskeletal:**

Loss of muscle strength
Joint/muscle pain
Chronic back pain
Sciatica
Stiff joints
Fingers blue when cold

- **Endocrine:**

Heat/cold intolerance
Excessive thirst

- **CNS:**

Changes in memory
Inability to concentrate
Loss of coordination
Tingling/numbness
Sleep disturbance
Strong emotion change
Mood swings

- **Women:**

Hot flashes
Vaginal itching/dryness
Unusual pelvic exam
Unusual breast exam
Do self breast exam

- **Men:**

Prostate enlarged or infected
Penile Pus/drainage
Swelling in groin
Nodule in testicle
Painful/tender groin
Do self testicular exam

For Women Only:

Age onset of menses: ____ History of irregular menses? ___ History of contraceptive use? ___

# of pregnancies ___ # of miscarriage ___# of children ___

Age onset of menopause ____

Patient Name: Date of Birth:

Chemical Exposure:
Did your mother take any drugs, alcohol, medications, or tobacco during her pregnancy with you? ___ Are you exposed to second hand smoke? ___ Do you use tobacco products? ____ If so, how many cigarettes/day? ______ Past smoker? ____ Yes ____ No If so, dates? ______________ Do you take antacids regularly?___Do you use recreational drugs?___ Any current or past addictions: ____Yes ____No If so, please explain ____________________________ Are you exposed to chemicals/fumes at work/home/hobby?___ Are you sensitive to strong odors? ___ Past exposure to pesticides?____ solvents?____ heavy metals? ____ radioactivity? other known chemicals? ____ If so, please explain: _________________________________ Do you use any of the following? ____natural cleaning products____air fresheners ___organic lawn care ____ scented candles Do you use any of the following? ____ acrylic nails ____ perfumes/cologne ___ artificially scented products Do you have silver fillings/amalgams?___ How many? ___

Health Maintenance:
Date of last full general checkup/ physical: _______________ If abnormal, please explain:
____
Date of last skin/dermatologic checkup: ______________ If abnormal, please explain:
____
Have you had a colonoscopy? ____ Yes _____ No Dates: __________________________________
If abnormal, please explain: ____
Date of last vision test: ___________ If abnormal, please explain: _____________________________
Date of last ophthalmologic exam? __________ If abnormal, please explain: _________________
Do you have regular dental exams? _____ Yes _____ No. If yes, how often? __________________

Safety:
Do you wear a seat belt? ____ Yes _____ No
Do you use a cell phone while driving? ___ Yes __No Do you text while driving? ___Yes ___No
Do you have a smoke detector in your home? ____ Yes ____ No
Do you have a carbon monoxide detector in your home? ____ Yes ____ No
Do you have a fire extinguisher in your home? ____ Yes ___ No

Stress:
Circle your usual level of stress. (1 = lowest) 1 2 3 4 5 6 7 8 9 10 For how long?_____

Health goals: Please circle all that apply.
Have more energy/vitality
Have more endurance
Sleep better
Eat better
Have less pain
Get sick less often
Have more libido/sex drive
Have less dependency on certain medication
Lose weight
Improve posture
Increase activity level
Have stronger bones
Have stronger muscles
Improve flexibility
Reduce stress
Have less brain fog
Balance moods
Gain motivation
Reduce risk of disease and cancer
Have better relationships
Have a healthier life longer

Willingness to change: Please circle: (0 = not willing, 10 = I'll do almost anything!
0 1 2 3 4 5 6 7 8 9 10