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, rice, almond	Frozen foods	Dark leafy greens	Herbal tea
Chicken	Cheese	Fast foods	Pasta	Alcohol
Turkey	Butter	Organic foods	Rice	Sodas
Fish	Margarine	Nuts & Seeds	Whole grains	Filtered water
Tuna fish		Flax/Fish oil	White flour	Diet foods/plans
Pork		Fresh fruit	Refined sugar	Artificial 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:

Please indicate the date of your last:	Abnormal?
Full general checkup/ physical ________________________	Y / N
Skin/dermatologic checkup__________________________	Y / N
Colonoscopy____	Y / N
DEXA Bone scan______________________________________	Y / N
Vision/ophthalmologic exam__________________________	Y / N
Dental exam____	Y / N
For *men*: PSA and Prostate exam_______________________	Y / N
For *women*: Mammogram _____________________________	Y / N
PAP/Pelvic exam__________________________	Y / N

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