

Health Intake Form

Durango Natural Medicine

"Invoking the Healing Power of Nature"

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Patient Note: This is a confidential record of your medical history. It will not be released except when you have authorized me to do so. Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Mark anything that you do not understand with a question mark. Thank you.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M F SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Wk Phone: _____ Cell: _____

Occupation: _____ Employer: _____

Is it OK to call you at work? Yes / No

Retired: _____

Is it OK to e-mail you personal medical information? Yes / No

E-Mail Address: _____

Name of Emergency Contact: _____ Phone: _____

Name of Spouse or Partner: _____

Married ___ Separated ___ Divorced ___ Widowed ___ Single ___ Partnership ___

How did you hear about this clinic?

List the most important health concerns in order of their significance to you.

1. _____
2. _____
3. _____
4. _____
5. _____

How are you hoping that we can help you today?

Your Opinions About Your Health

What impact have your symptoms had on your life? _____

Do you have any ideas about what is causing or contributing to your condition?

What do you feel needs to happen for you to get better? _____

Is there any additional information about your health that you would like to add?

Are you willing to make changes in your lifestyle to address your illness (for example - quitting smoking, begin an exercise program, dietary changes, etc.)?

How much change are you willing to make at this time for improving your health?

Circle One: MINIMAL SOME COMPLETE

Are you currently receiving healthcare anywhere else? Yes / No

If yes, where and from whom?

If no, when and where did you last receive medical or health care?

Do you have any contagious diseases at this time? Yes / No
If yes, what?

Weight: _____ Weight 1 year ago: _____ Maximum Weight: _____ when?

Height: _____ Desired weight: _____ Date of last physical exam?

Personal Habits

Do you eat three meals per day? YES NO

How many hours of sleep per night?

Do you sleep well? YES NO

Do you wake up feeling rested?

YES NO

Have a supportive relationship?

YES NO

Do you smoke? Yes / No

packs/wk? _____

Smoke previously? Yes / No

Years? _____ packs/wk? _____

Had any major traumas?

YES NO

Have a history of abuse?

YES NO

Physical? _____

Sexual? _____

Emotional? _____

Do you use Alcohol?

YES NO

How often? _____ How much?

Religious or Spiritual practice?

YES NO

Do you enjoy your job?

YES NO

Do you take vacations?

YES NO

Do you spend time outside?

YES NO

Do you exercise?

YES NO

How often and what type?

Do you read? Yes / No

hrs/wk? _____

Do you watch TV? Yes / No

hrs/wk? _____

Do you eat out often?

YES NO

Do you eat sugar?

YES NO

Do you eat salt?

YES NO

Do you go on diets often?

YES NO

Do you use recreational drugs? Yes / No

How

often? _____

Do you drink coffee?
YES NO

Do you drink black tea?
YES NO

What types? _____

Do you drink cola?
YES NO

List the **medications** that you are currently taking, including dosage. Be sure to include things such as: Laxatives, Cortisone, Tranquilizers, Pain Reliever, Appetite suppressants, Thyroid medications, Antacids, Antibiotics, Sleeping pills and Birth Control Pills.

List all **vitamins, minerals, herbs, and homeopathic remedies** you are currently taking

Typical Daily Food Intake:

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

If you know your blood type, please tell us:

Family Health History:

*Age (if living) Health (G=good or P=poor) Age at Death (if deceased)

<u>Fill in Chart</u>	<u>Self</u>	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Child</u>
<u>*Age</u>							
<u>*Health</u>							
<u>*Age at Death</u>							
<u>Cause of Death</u>							
<u>"X" all that are applicable:</u>							
<u>Cancer</u>							
<u>Diabetes</u>							
<u>Heart Disease</u>							
<u>High Blood Pressure</u>							
<u>Stroke</u>							
<u>Epilepsy</u>							
<u>Mental Illness</u>							
<u>Asthma</u>							
<u>Hay Fever</u>							
<u>Hives</u>							
<u>Anemia</u>							
<u>Kidney Disease</u>							
<u>Glaucoma</u>							
<u>Tuberculosis</u>							
<u>Alcoholism/ Substance Abuse</u>							
<u>Other Illnesses:</u>							

Childhood Illnesses that you have had: Scarlet fever Diphtheria Rheumatic fever
 Mumps Measles Chicken pox German Measles

Immunizations that you have had:

- Polio Pertussis Tetanus shot Diphtheria Measles/Mumps/Rubella
 Other _____

X-Rays and Special Studies

Please list any Electrocardiograms, electroencephalograms, x-rays, CAT scans, MRIs or other studies you have had done.

Hospitalization and Surgeries

Please list any hospitalizations and/or surgeries that you have had:

Major Trauma (Emotional or Accidental)

Please describe:

Allergies

To any drugs or medications?

To any foods? _____

To any environmental pollens/grasses?

Other? _____

Endocrine System (Please circle Yes- I have this now, Never- had, Past- had in the past.)

Hypothyroid?	Yes/ Never/Past	Excessive thirst?	Yes/ Never/Past
Hyperthyroid?	Yes/ Never/Past	Excessive hunger?	Yes/ Never/Past
Hypoglycemia?	Yes/ Never/Past	Poor appetite?	Yes/ Never/Past
Diabetes?	Yes/ Never/Past	Unexplained weight loss?	
Fatigue?	Yes/ Never/Past	Yes/ Never/Past	
Heat or cold intolerance?		Easy weight gain?	Yes/ Never/Past
Yes/ Never/Past		Seasonal depression?	Yes/ Never/Past

Immune System

Slow wound healing?	Yes/ Never/Past	Reactions to vaccinations?	Yes/ Never/Past
Chronic fatigue syndrome?	Yes/ Never/Past	Chronic infections?	Yes/ Never/Past
Chronically swollen glands?	Yes/ Never/Past		

Nervous System

Seizures?	Yes/ Never/Past	Paralysis?	Yes/ Never/Past
Muscle weakness?	Yes/ Never/Past	Numbness or tingling?	Yes/ Never/Past
Loss of memory?	Yes/ Never/Past	Easily stressed?	Yes/ Never/Past
Vertigo?	Yes/ Never/Past	Loss of balance?	Yes/ Never/Past
Dizziness?	Yes/ Never/Past	Lightheaded?	Yes/ Never/Past
Trembling hands/feet?	Yes/ Never/Past	Poor concentration?	Yes/ Never/Past
Mood swings?	Yes/ Never/Past	Slurred speech?	Yes/ Never/Past
Tics?	Yes/ Never/Past		

Skin

Rashes?	Yes/ Never/Past	Eczema?	Yes/ Never/Past
Hives?	Yes/ Never/Past	Dryness?	Yes/ Never/Past
Acne, boils?	Yes/ Never/Past	Itching?	Yes/ Never/Past
Color changes?	Yes/ Never/Past	Perpetual hair loss?	Yes/ Never/Past
Lumps?	Yes/ Never/Past	Night sweats?	Yes/ Never/Past
Ulceration?	Yes/ Never/Past	Sores?	Yes/ Never/Past
Shingles?	Yes/ Never/Past	Change in hair/nails?	Yes/ Never/Past

Head

Headaches?	Yes/ Never/Past	Head injury?	Yes/ Never/Past
Migraines?	Yes/ Never/Past	Jaw/TMJ problems?	Yes/ Never/Past
Lightheadedness?	Yes/ Never/Past	Loss of balance?	Yes/ Never/Past
Dizziness?	Yes/ Never/Past		

Eyes

Spots in Eyes?	Yes/ Never/Past	Cataracts?	Yes/ Never/Past
Impaired vision?	Yes/ Never/Past	Glasses/Contacts?	Yes/ Never/Past
Blurriness?	Yes/ Never/Past	Eyestrain?	Yes/ Never/Past
Color blindness?	Yes/ Never/Past	Tearing or dryness?	Yes/ Never/Past
Double vision?	Yes/ Never/Past	Glaucoma?	Yes/ Never/Past
Eye pain?	Yes/ Never/Past	Night blindness?	Yes/ Never/Past
Swollen eyes?	Yes/ Never/Past	Circles under Eyes?	Yes/ Never/Past

Ears

Impaired hearing?	Yes/ Never/Past	Ringing in ears?	Yes/ Never/Past
Ear aches/Itch?	Yes/ Never/Past	Excessive earwax?	Yes/ Never/Past

Nose & Sinuses

Frequent Colds?	Yes/ Never/Past	Nose Bleeds?	Yes/ Never/Past
Stuffiness?	Yes/ Never/Past	Sinus Problems?	Yes/ Never/Past
Post Nasal Drip?	Yes/ Never/Past	Hayfever Allergies?	Yes/ Never/Past
Loss of Smell?	Yes/ Never/Past		

Mouth & Throat

Frequent sore throat?	Yes/ Never/Past	Sore Tongue?	Yes/ Never/Past
Sores in mouth?	Yes/ Never/Past	Gum problems?	Yes/ Never/Past
Hoarseness?	Yes/ Never/Past	Dental Problems?	Yes/ Never/Past
Difficulty Swallowing?	Yes/ Never/Past	Difficulty Speaking?	Yes/ Never/Past
Loss of Taste?	Yes/ Never/Past	Dental Cavities?	Yes/ Never/Past
Teeth Grinding?	Yes/ Never/Past	Jaw Clicks?	Yes/ Never/Past
Sore Lips?	Yes/ Never/Past	Copious saliva?	Yes/ Never/Past

Neck

Pain or Stiffness?	Yes/ Never/Past	Lumps?	Yes/ Never/Past
Swollen glands?	Yes/ Never/Past	Goiter?	Yes/ Never/Past

Respiratory

Cough?	Yes/ Never/Past	Sputum?	Yes/ Never/Past
Spitting up blood?	Yes/ Never/Past	Bronchitis?	Yes/ Never/Past
Wheezing?	Yes/ Never/Past	Pleurisy?	Yes/ Never/Past
Difficulty breathing?	Yes/ Never/Past	Emphysema?	Yes/ Never/Past
Pain with breathing?	Yes/ Never/Past	Pneumonia?	Yes/ Never/Past
Shortness of breath?	Yes/ Never/Past	Asthma?	Yes/ Never/Past
- While lying down?	Yes/ Never/Past	Positive TB test?	Yes/ Never/Past
- At night?	Yes/ Never/Past		

Cardiovascular

Heart Disease?	Yes/ Never/Past	Angina?	Yes/ Never/Past
High/Low Blood Pressure?	Yes/ Never/Past	Murmurs?	Yes/ Never/Past
Blood Clots?	Yes/ Never/Past	Fainting?	Yes/ Never/Past
Phlebitis?	Yes/ Never/Past	Palpitations/Fluttering?	Yes/ Never/Past
Rheumatic Fever?	Yes/ Never/Past	Chest Pain?	Yes/ Never/Past
Swelling in ankles?	Yes/ Never/Past	Stroke/Heart Attack?	Yes/ Never/Past

Gastrointestinal

Trouble swallowing?	Yes/ Never/Past	Black Stools?	Yes/ Never/Past
Jaundice?	Yes/ Never/Past	Diverticulitis/losis?	Yes/ Never/Past
Nausea?	Yes/ Never/Past	Liver disease?	Yes/ Never/Past
Vomiting?	Yes/ Never/Past	Vomiting blood?	Yes/ Never/Past
Heartburn / Reflux?	Yes/ Never/Past	Hiatal hernia?	Yes/ Never/Past
Belching or passing gas?	Yes/ Never/Past	Extreme appetite?	Yes/ Never/Past
Decreased appetite?	Yes/ Never/Past	Tired after eating?	Yes/ Never/Past
Blood in stool?	Yes/ Never/Past	Mucus in Stool?	Yes/ Never/Past
Diarrhea?	Yes/ Never/Past	Constipation?	Yes/ Never/Past
Hemorrhoids?	Yes/ Never/Past	Laxative Use?	Yes/ Never/Past
Bowel movement how often?		Colitis?	Yes/ Never/Past
Is this a change?		Anal itching?	Yes/ Never/Past

<u> </u>			
Gallbladder disease?	Yes/ Never/Past	Pain or cramps?	Yes/ Never/Past
Ulcers?	Yes/ Never/Past	Stomach pain?	Yes/ Never/Past
Change in thirst?	Yes/ Never/Past		

Urinary

Pain on urination?	Yes/ Never/Past	Increased frequency?	Yes/ Never/Past
Frequency at night?	Yes/ Never/Past	Unable to hold urine?	Yes/ Never/Past
Bladder Infections?	Yes/ Never/Past	Kidney stones?	Yes/ Never/Past
Unable to urinate?	Yes/ Never/Past		

Circulation

Cold hands/feet?	Yes/ Never/Past	Varicose veins?	Yes/ Never/Past
Deep leg pain?	Yes/ Never/Past	Anemia?	Yes/ Never/Past
Easy bleeding/bruising?	Yes/ Never/Past	Thrombophlebitis?	Yes/ Never/Past

Musculoskeletal

Joint pain or stiffness?	Yes/ Never/Past	Broken bones?	Yes/ Never/Past
Muscle spasms/cramps?	Yes/ Never/Past	Back/Neck pain?	Yes/ Never/Past
Weakness?	Yes/ Never/Past	Arthritis?	Yes/ Never/Past

Emotional

Depression?	Yes/ Never/Past	Tension?	Yes/ Never/Past
Mood swings?	Yes/ Never/Past	Suicidal thoughts?	Yes/ Never/Past
Job stress?	Yes/ Never/Past	Anxiety/nervousness?	Yes/ Never/Past
Recent divorce or breakup?	Yes/ Never/Past	Financial stress?	Yes/ Never/Past

Death of Someone close? Yes/ Never/Past	Seasonal depression? Yes/ Never/Past
Treated for emotions? Yes/ Never/Past	

Menstrual History

Age at onset of menses? _____	How many days does your period last? _____
First day of last menstrual period: _____	Are your cycles regular? YES NO
Do you bleed between cycles? YES NO	Any clotting? YES NO
Number of days between 1st day of one period and the 1st day of the next? _____	
Do you have any difficulty with gyn exam? YES NO	
Date of last PAP smear? _____	Was it normal? YES NO

Do you have any problems with the following:

Premenstrual tension? YES NO	Pain? YES NO
Heavy bleeding? YES NO	Irregularity? YES NO
Bleeding between periods? YES NO	Breast pain/tenderness? YES NO
Cramping? YES NO	Abnormal PAPs? YES NO

Pregnancy History

No. of pregnancies? _____	No. of miscarriages? _____
No. of tubal/ectopic pregnancies? _____	Any difficulty conceiving? YES NO
No. of live births? _____	No. of abortions? _____
Any complications of pregnancy? _____	

Birth Control History

Are you sexually active? YES NO	Sexual Orientation? _____
If yes, what birth control are you currently using? _____	

What birth controls have you used in the past (please include dates)?

Birth control pills		What kind?
YES	NO	_____
IUD		What kind?
YES	NO	_____
Cervical Cap		What kind?
YES	NO	_____
Sponges		Condoms
YES	NO	YES NO
Foam		Diaphragm
YES	NO	YES NO
Other?		Any problems encountered?
_____		_____
Any hormone medications used?		What kind?
YES	NO	_____
DES		Provera
YES	NO	YES NO
Steroids		Estrogen
YES	NO	YES NO
Thyroid meds		Morning After Pill
YES	NO	YES NO
Other:		Cortisone
_____		YES NO

Women's General History

Do you do self-breast exams?		Regularly?
YES	NO	YES NO

Do you have any pain with intercourse?
 YES NO

Do you have any problems with:

Endometriosis?		Cancer?
YES	NO	YES NO
Pelvic Inflamm. Disease?		Hot Flashes?
YES	NO	YES NO
Difficulty Conceiving?		Cervical dysplasia?
YES	NO	YES NO
Nipple discharge?		Bladder infections?
YES	NO	YES NO
Breast lumps/tumors?		Hysterectomy?
YES	NO	YES NO
Sexual difficulties?		Cervical abnormality?

YES NO
 Menopausal symptoms?
 YES NO
 Uterine abnormality?
 YES NO
 Sexually Trans. Disease?
 YES NO

YES NO
 Uterine abnormality?
 YES NO
 Ovarian cysts?
 YES NO
 Vaginal discharge?
 YES NO

- If yes, circle which ones:

Herpes
 Chlamydia
 Vaginal Infections

Venereal Warts
 Syphilis

Gonorrhea
 Trichomonas

Is there anything else?

Men's Health History

Hernias?	Yes/ Never/Past	Testicular Masses?	Yes/ Never/Past
Penile pain?	Yes/ Never/Past	Testicular pain?	Yes/ Never/Past
Erectile difficulty?	Yes/ Never/Past	Testicular swelling?	Yes/ Never/Past
Penile discharge?	Yes/ Never/Past	Prostate problems?	Yes/ Never/Past
Sexually active?	Yes/ Never/Past	Sexual Orientation?	
Do you use protection?	Yes/ Never/Past	Premature ejaculation?	Yes/ Never/Past
- If yes, what type?		Impotence?	Yes/ Never/Past
Any penile sores?		History of inguinal hernia?	Yes/ Never/Past
Monogamous relationship?	Yes/ Never/Past		
Sexually Transmitted disease?	Yes/No		

If yes, circle which ones?

Chlamydia Gonorrhea Condyloma Herpes Syphilis Venereal Warts

Hobbies & Interests

What are your main interests and hobbies?

What do you enjoy the most in life?

Thank you for completing and returning your Health Intake Form to Durango Natural Medicine. Please let us know if you have any questions regarding this form or our healthcare practice.

Cancellation Policy

New patient appointments must be cancelled 48 business hours (Monday-Friday) in advance or they will be billed. A first office visit with Dr. Utter that is not cancelled 48 hours in advance will be charged \$105.00.

All appointments for established patients must be cancelled 24 business hours (Monday-Friday) in advance or they will be charged the full appointment fee of \$105.00.

Thank you,

Durango Natural Medicine

Signature

Date