THE CENTER FOR
TRUE HARMONY
WELLNESS & MEDICINE

PATIENT INTAKE FORMS

Name: Date:

Preferred Name: Birth Date:

Current health problems/concerns:

MEDICAL HISTORY

ALLERGIES

Please list drug allergies, with the reactions you have:

Please list food allergies, with the reactions you have:

Please list environmental allergies, with the reactions you have:

MEDICAL INFORMATION

General Health ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Medications:

Vitamins & Herbals & Homeopathic:

Surgeries/Hospitalizations

Date	Hospital	Diagnosis/Surgery	Physician

Pregnancies (include miscarriages/abortions).

Please include any complications including bloodpressure issues, gestational diabetes, induction, etc.

Date	How far along	Sex of baby	Weight of baby	Problems/Complications

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MEDICAL HISTORY CONTINUED

Medical History

☐	Arthritis	☐	Asthma	☐	Anemia	☐	Blood Transfusion	☐	Cancer
☐	Chronic Fatigue	☐	Clotting/Bleeding Disorders	☐	Diabetes	☐	Epilepsy	☐	Fibromyalgia
☐	Heart Problems	☐	Hepatitis	☐	Herpes	☐	Hight Blood Pressure	☐	Hight Cholesterol
☐	Lupus	☐	Migraine Headaches	☐	Osteoporosis	☐	Phlebitis	☐	Recurrent UTIs or Interstitial Cystitis
☐	Stomach Issues	☐	Stroke	☐	Thyroid Disorders	☐	Varicose Veins		

Childhood diseases such as German measles or chicken pox:

Other/Specify:

Preferred Pharmacy:

MENTAL/EMOTIONAL

Do you experience or have history of any of the following

☐ Depression ☐ Anxiety ☐ ADHD ☐ Eating Disorders ☐ Other Behavioral Conditions

If yes, please put dates (past/current), and treatments (past/current)

Any current or past history of physical abuse? ☐ Yes ☐ No Or sexual abuse? ☐ Yes ☐ No

DIET/EXERCISE

Dietary preferences/restrictions:

What do you like to do for exercise?

How often do you exercise? For how many minutes?

SOCIAL HISTORY

Tobacco use: ☐ Yes ☐ No How much? How long?

When did you quit (if applicable)?

Caffeine use: ☐ Yes ☐ No How much? How long?

When did you quit (if applicable)?

Alcohol use: ☐ Yes ☐ No How much? How long?

When did you quit (if applicable)?

Marijuana use: ☐ Yes ☐ No How much? How long?

When did you quit (if applicable)?

Other drug use? ☐ Yes ☐ No What? How long?

When did you quit (if applicable)?

Are you currently employed? ☐ Yes ☐ No

Do you currently have housing? ☐ Yes ☐ No

Do you have difficulty affording food, clothing, or housing? ☐ Yes ☐ No

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LIFE STRESSES

Family, work, self, etc.

FAMILY HISTORY

Please include diseases, age of person if alive and age/cause of death if deceased.

Mother: Father:

Sisters: Brothers:

Maternal Grandmother: Maternal Grandfather:

Paternal Grandmother: Paternal Grandfather:

Aunts: Uncles:

Children:

Other:

GYNECOLOGICAL HISTORY

First day of last period:

Date of last PAP smear: Date of last pelvic exam:

Have you EVER had an abnormal PAP? ☐ Yes ☐ No When? Results?

Treatment?

Age first period began:

Have you had the HPV vaccine? ☐ Yes ☐ No If yes, when?

Normally (not on pills) how many days from the start of one period to the start of the next?

Number of days of flow: Bleeding amount? Cramping Amount:

Do you have a history of infertility? ☐ Yes ☐ No If yes, please describe:

Have you ever had any history of sexually transmitted infections? ☐ Yes ☐ No

If yes, please describe:

REVIEW OF SYSTEMS: ANY PRESENT PROBLEMS YOU ARE EXPERIENCING (CIRCLE)

General

Fever Chills Hot flashes Unusual hair growth

Skin eruptions Weight Change

Head

Headaches Dizziness Visual changes Hearing defects

Sinus trouble Fainting

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REVIEW OF SYSTEMS CONT: ANY PRESENT PROBLEMS YOU ARE EXPERIENCING (CIRCLE)

Abdomen

Bloating Heartburn/indigestion Cramps/pain Nausea/vomiting

Diarrhea Constipation Hemorrhoids Bloody/tarry stools

Chest

Chest pain Shortness of breath heart murmur MVP

Palpitations Chronic cough wheezing, Other:

Breasts

Lumps Bleeding Nipple discharge Tenderness, Other:

Bladder

Frequent urination Painful urination Blood in urine Inability to hold urine

Inability to empty bladder Need to get up at night to urinate

Other concerns:

CURRENT HEALTH CARE PROVIDERS

Current Health Care Providers:

Would any of these healthcare providers prefer us to follow-up after your visit here?

Name:

Address:

AUTHORIZATION:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for all service rendered on my dependents or my behalf. I consent to/and authorize treatment for the above named patient. I authorize the release of any information requested by health professionals participating in my care.

Name:

Signatire: Date:

How did you hear about us?

Online search? Friend? What were the keywords you searched?

Website? Friend? Who may we thank?

Other?

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GYN ADDITIONAL QUESTIONS

Do you experience premenstrual symptoms? ☐ Yes ☐ No When do they start?

Are there any current changes to your normal pattern? ☐ Yes ☐ No

Bleeding between periods? When?

Unusual pelvic pain or fullness? When & describe:

How long has this occurred? Treatments you have tried?

Past history of tubal infection? ☐ Yes ☐ No

Other:

Have you ever had a mammogram? ☐ Yes ☐ No Date:

Do you do self-breast exams? ☐ Yes ☐ No

SEXUAL HISTORY

Are you sexually active? ☐ Yes ☐ No

How many partners have you had in the past year?

Do you have male partners, female partners, or both?

Are you trying to get pregnant? ☐ Yes ☐ No

For how long have you tried?

Current birth control method: How long?

Past birth control methods:

Problems experienced with any birth control methods:

Any sexual concerns to discuss?

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OB ADDITIONAL QUESTIONS

SOCIAL HISTORY/EXPOSURE:

Was this a planned pregnancy? ☐ Yes ☐ No

Spouse/Partner's name:

Do you have any religious objectives to any form of medical treatment that you would like to make us aware of (i.e. refusal of blood transfusions)? ☐ Yes ☐ No If so, please elaborate:

Do you have cats? ☐ Yes ☐ No

If yes, do you handle the litter box?

Please list any sources of chemical or radiation exposure that you encounter:

Did you use any assisted reproductive technology to become pregnant? (Ex: IUI, IVF, etc)

If yes please describe and note fertility specialist

GENETIC HISTORY:

Will you be 35 or older at the time the baby is born? ☐ Yes ☐ No

Will the father/sperm donor be 50 or older? ☐ Yes ☐ No

Have either you or the baby's father had a child born with a birth defect? ☐ Yes ☐ No

If yes, please describe:

Did either you or the baby's father have a birth defect yourselves? ☐ Yes ☐ No

If yes, please describe:

Please describe any abnormalities that have occurred in children in your family or the baby's family (for example Down Syndrome, birth defects, deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis).

How is the affected child/person related to you?

Do either you have a history of pregnancy losses (miscarriages or stillborn)? ☐ Yes ☐ No

Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please circle if either you or the baby's father/sperm donor is one of these backgrounds:

Jewish ancestry? ☐ Yes ☐ No If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No

Date: Result:

African-American? ☐ Yes ☐ No If yes, have you had Sickle Cell screening? ☐ Yes ☐ No

Date: Result:

Do you or the baby's father/sperm donor have a history of twins/ multiple babies? ☐ Yes ☐ No

If yes, who?

Please list any other concerns you have about birth defects or inherited disorders: