Desert Wellness Center

Family Medicine Using Modern Science and Ancient Wisdom

New Patient Intake

Name: _____ Date of Birth:_____ Today's Date:_____

List of Complaints (in order of importance):

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

Allergies to Medications/Food:

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

Current Medications and Supplements (include dosage): _____

_____

_____

_____

Previous Surgeries and Hospitalizations, include date: _____

_____

_____

Please list date of your last:

Blood Work:_____ Dental Exam:_____ Eye Exam: _____

Colonoscopy:_____ Chest x-ray:_____ Other Imaging:_____

Pap Smear:_____ Bone Scan:_____ Mammogram:_____

Please indicate if you have had the disease (D) or were immunized (I):

Measles: D I Mumps: D I Rubella: D I Hemophilis (Hib): D I

Tetanus: D I Shingles: D I Chicken Pox: D I Hepatitis B: D I

HPV: D I Whooping Cough: D I German Measles: D I Other:_____

Family History

Family Member	**Age if Living**	**Age of Death**	**Reason of Death**
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

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Disease	**Family Member**
Heart attack/stroke	
Cancer (include type)	
Mental Illness	
Heart Disease	
High Blood Pressure	
Osteoporosis	
Asthma/allergies	
Autoimmune(RA,Lupus,etc)	
Diabetes	

Please indicate Yes (Y), No (N), or Past (P):

Antacids: Y N P Smoking: Y N P Packs per day & number of years _____

Analgesics: Y N P Coffee: Y N P Cups per day if yes or past_____

Laxatives Y N P Alcohol Y N P Amount if yes or past_____

Steroids Y N P Soda Y N P Amount if yes or past _____

Recreational Drugs Y N P

Addictions and/or treatment for addictions: Y N P Explain: _____

Height: _____ Current Weight: _____ Ideal Weight: _____

Maximum Weight as Adult: _____ Minimum Weight as adult: _____

Exercise: How often: _____ Type: _____

Sleep: Amount: _____ Wake Refreshed?_____ Trouble Falling or Staying Asleep?_____

Social Life:

Job: _____ Enjoy Job? _____

Hobbies: _____

Relationship: Married Single In a relationship

Satisfied with Significant Relationship? _____

History of Mental/Physical/emotional Abuse? _____

Please describe your typical meals:

Breakfast	Lunch	Dinner

Snacks:_____ Beverages:_____

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Review of Systems

Circle Yes (Y), No (N) or Past (P):

Skin:

Rash: Y N P	Eczema: Y N P	Color Change: Y N P
Hives: Y N P	Cancer: Y N P	Abnormal Mole: Y N P
Psoriasis: Y N P	Warts: Y N P	Dry/ Itchy: Y N P

Head:

Migraines: Y N P	Dandruff: Y N P	Oily/dry Hair: Y N P
Headache: Y N P	Hair Loss: Y N P	Head Injury: Y N P

Nose:

Nose bleeds: Y N P	Allergies: Y N P	Frequent Colds Y N P
Polyps: Y N P	Congestion: Y N P	Problems Smelling Y N P

Eyes:

Dryness: Y N P	Cataracts: Y N P	Pain: Y N P
Itching: Y N P	Glaucoma: Y N P	Watery/Discharge: Y N P
Redness: Y N P	Styes: Y N P	Vision Problems: Y N P

Mouth/Throat/Neck:

Cavities: Y N P	Goiter: Y N P	Problems speaking: Y N P
Dentures: Y N P	Gum Disease: Y N P	Problems tasting: Y N P
Sores: Y N P	Sore throat: Y N P	Problems swallowing: Y N P
Neck Stiffness: Y N P	Swollen Glands: Y N P	

Respiratory:

Asthma: Y N P	Cough: Y N P	Shortness of Breath: Y N P
Emphysema: Y N P	TB: Y N P	Wheezing: Y N P
Pneumonia: Y N P	Bronchitis: Y N P	Pain with Breathing: Y N P

Cardiovascular:

Palpitations: Y N P	Heart Attack: Y N P	High Blood Pressure: Y N P
Chest Pain: Y N P	Rheumatic Fever: Y N P	Arrhythmias: Y N P
Murmurs: Y N P	Edema: Y N P	Low Blood Pressure: Y N P

Urinary Tract:

Incontinence: Y N P	Kidney Stones: Y N P	Frequent Infections: Y N P
Urgency: Y N P	Blood in Urine: Y N P	Pain with Urination: Y N P

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Gastrointestinal:

Heartburn: Y N P	Vomiting: Y N P	Change in Appetite: Y N P
Indigestion: Y N P	Ulcers: Y N P	Gall Bladder Disease: Y N P
Gas/Bloating: Y N P	Hemorrhoids: Y N P	Pancreatitis: Y N P
Constipation: Y N P	Liver Disease: Y N P	Stomach Pain: Y N P
Diarrhea: Y N P	Nausea: Y N P	Bowel Movements: #_____/day week

Male Genitalia:

STD's Y N P	Hernia: Y N P	Erectile Dysfunction: Y N P
Discharge: Y N P	Prostate disease: Y N P	Testicular Pain/swelling: Y N P
Pain: Y N P	Sexually Active: Y N P	Frequent Night urination: Y N P

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Female Genitalia:

Age of First Menses: _____ First Day of Last Menses: _____ Length of Menses: _____

Age of Menopause: _____ Birth control previously or currently used: _____

Times Pregnant: _____ Children: _____ Miscarriages: _____ Abortions: _____

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Abnormal Paps: Y N P	Discharge: Y N P	Pain with intercourse: Y N P
PMS: Y N P	Odor: Y N P	Healthy Libido: Y N P
STD: Y N P	Heavy Bleeding: Y N P	Sexually Active: Y N P
Vaginitis: Y N P	Vaginal Dryness: Y N P	Menstrual Cramping: Y N P

Musculoskeletal:

Weakness: Y N P	Tremors: Y N P	Leg Cramps: Y N P
Stiffness: Y N P	Arthritis: Y N P	Pain: Y N P

Nervous:

Paralysis: Y N P	Sciatica: Y N P	Numbness/Tingling: Y N P
Seizures: Y N P	Fainting: Y N P	Carpel Tunnel: Y N P

Mental/Emotional:

Depression: Y N P	Suicidal: Y N P	Psych Hospitalization: Y N P
Anxiety: Y N P	Fear/Panic: Y N P	Bipolar: Y N P
Eating Disorder: Y N P	Irritability: Y N P	Obsessive: Y N P