NHIC Patient History Intake Form

Name:

Date:

Date of Birth:

Primary Care Phys.

Please attach any additional information that is not covered in the form below or any information that you'd like your health care provider to have for your initial clinic office visit.

Sex: Male ____ Female_____

Race: Caucasian, African American, Hispanic, Other_____(please write in)

Chief complaint- Why are you here to see the doctor? _____

_____

What are your health care goals for your treatment at the Natural Health Improvement Center?

_____

_____

History of present illness:

When did your illness or problem start? _____

What are your symptoms? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

What have you done for this problem? _____

Past Medical History

Please check √ any of the following that apply to you:

- ☐ Diabetes
- ☐ Heart Attack
- ☐ Stroke/TIA
- ☐ Hypertension
- ☐ Cancer, Type:_____
- ☐ Tuberculosis
- ☐ Lung disease (asthma, emphysema, other)
- ☐ Ulcers, IBS, gastro disease
- ☐ Renal failure/kidney disease
- ☐ History of blood clots
- ☐ Depression
- ☐ Anxiety
- ☐ Migraines/headaches
- ☐ Arthritis/other joint or muscle diseases, if yes, where?
  _____
- ☐ Fibromyalgia
- ☐ Other disease/condition not listed above:
  _____

Family History (mother, father, siblings)

☐ Unknown Family History

Please check all that apply to your family medical history and please specify which relative.

- ☐ Diabetes _____
- ☐ Hypertension_____
- ☐ Heart Attack_____
- ☐ Stroke or TIA_____
- ☐ Lung disease (asthma, emphysema, other)
  _____
- ☐ Cancer_____
- ☐ Tuberculosis_____
- ☐ Ulcers, IBS, gastro disease_____
- ☐ Kidney disease/failure_____
- ☐ Neurological disease (Alzheimer's/Multiple Sclerosis/other) _____
- ☐ High cholesterol _____
- ☐ Arthritis _____

Other diseases/conditions not listed above: _____

_____

Allergies: List name of medicine/animal/food/environmental items:

Item:_____ reaction:_____

Item:_____ reaction:_____

Item:_____ reaction:_____

Surgeries, procedures and hospitalizations (attach additional page if necessary):

Date of surgeries: Type of surgery:

_____ _____

_____ _____

_____ _____

Procedures:

Colonoscopy date done:_____ outcome:_____

Bone Density date done:_____ outcome:_____

Other (write in procedure):

_____ date done:_____ outcome:_____

_____ date done:_____ outcome:_____

Hospitalizations (write in where and reason for admission to hospital):

_____ date:_____ outcome:_____

_____ date:_____ outcome:_____

Social history:

Exercise Regularly ☐ Yes ☐ No If yes, what?_____ How often?_____

Alcohol? ☐ Yes ☐ No If yes, how much?_____How often?_____

Over-the-counter meds ☐ Yes ☐ No Type:_____How often?_____For what?_____

Recreational drugs ☐ Yes ☐ No Type: _____How often? _____ # of years: _____

Married ☐ Yes ☐ No # of children:____ Ages: _____

Employment: _____ Hobbies: _____

Exposure to carcinogens/ environmental toxins? What:_____ When:_____

Diet, list what you eat in a typical day: Specific food restrictions: dairy/wheat/gluten/eggs/soy/corn/other

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Review of systems (check any problems you have):

General:
- ☐ weight gain
- ☐ weight loss
- ☐ appetite loss
- ☐ appetite excess
- ☐ fever
- ☐ chills
- ☐ fatigue
- ☐ night sweats

Skin:
- ☐ Rashes
- ☐ Bruises
- ☐ easy bruising or bleeding tendencies
- ☐ skin discolorations or lesions

Head:
- ☐ Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Head trauma

Eyes:
- ☐ Visual changes
- ☐ Near/farsighted
- ☐ Double vision
- ☐ Dryness
- ☐ Watering

Ears:
- ☐ Ringing
- ☐ Dizziness
- ☐ Pain
- ☐ Drainage
- ☐ Wax
- ☐ Hearing loss

Lymphatics:
- ☐ Swollen lymph nodes in armpits or groin, other

Nose:
- ☐ Drainage
- ☐ Sinus pressure or pain
- ☐ Nosebleeds
- ☐ Seasonal allergy symptoms

Mouth/Throat
- ☐ Dental disease
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Pain
- ☐ Difficulty swallowing
- ☐ Masses sores

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Phlegm
- ☐ Chest pain
- ☐ History of TB
- ☐ History of pneumonia

Cardiovascular:
- ☐ Chest pain
- ☐ Shortness of breath with activity of laying down
- ☐ Swelling of extremities
- ☐ Heart palpitations
- ☐ Irregularity or racing
- ☐ Pain in legs with walking

Gastrointestinal:
- ☐ Difficulty swallowing
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Bloody stools
- ☐ Constipation
- ☐ Gas/Bloating
- ☐ Change in bowel habits

Genitourinary:
- ☐ Painful urination
- ☐ Urinary frequency/hesitancy/urgency
- ☐ Urination at night

Males:
- ☐ Penile discharge
- ☐ Impotence
- ☐ Testicular masses
- ☐ Difficulty urinating

Endocrine:
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Skin or hair changes
- ☐ Cold/heat intolerance
- ☐ Fatigue
- ☐ Hormonal therapy

Musculoskeletal:
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Arthritis
- ☐ Muscle pain
- ☐ Numbness/tingling of extremities
- ☐ Spinal scoliosis
- ☐ Injuries

Neuropsychiatric:
- ☐ Seizures
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Memory difficulties
- ☐ Emotional disturbances

Gynecological **(the rest of this page is for WOMEN only)**:

Breasts:
- ☐ Sore
- ☐ Masses
- ☐ Discharge Right/Left
- ☐ Do you do regular self-breast exams?
- ☐ Told you have fibrous tissue?

First day of last menstrual period: _____ Duration: _____days How often?_____
- ☐ Irregular periods, if yes, describe_____
- ☐ Spotting between periods
- ☐ Painful periods/cramps/clots

Any vaginal symptoms: itching/burning/discharge/painful intercourse/other (circle positives)

Last mammo- or thermogram: _____ Family history breast cancer? Yes____ no ____ who?_____
Number of pregnancies_____ Number of live births _____C-sections_____Stillbirths/abortions, spontaneous or other ____

Hysterectomy? Yes ___ No ___ If yes, total or partial (circle) Other procedures done? Yes ____ No ____ If yes, tubal ligation/D&C/ablation/other (circle positives).