



Wildwood Medicine

Adult Intake

PATIENT INFORMATION

Date(mo/day/yr): ____/____/____

Name: _____

Date of birth(mo/day/yr): ____/____/____

Sex: M / F

Address: _____

Occupation: _____

City: _____ Zip: _____

Phone (primary): _____ (secondary): _____ Employer: _____

E-mail: _____

Emergency contact: _____

Relationship: _____

Phone (primary): _____

(secondary): _____

Medical doctor: _____

MD Tel: _____

Names of other healthcare providers: _____

How did you hear about the clinic? _____

Optimal health is only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this confidential overview will greatly assist our understanding of your healthcare needs and desires.

HEALTH INFORMATION

What is the main purpose of this appointment? _____

To what extent does this problem interfere with your daily activities (i.e. sleep, work, hobbies, etc.)

What other treatments have you received for this problem? _____

Please list any other health concerns (physical, emotional, or mental) in order of importance.

1. _____

2. _____

3. _____

If you are female, are you currently pregnant? Y / N

How do you rate your overall health? Poor Fair Good Excellent

How do you rate your overall energy? Poor Fair Good Excellent



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MEDICAL HISTORY

Indicate if you had any of the following childhood illnesses (Check ✓):

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Frequent ear infections or colds | <input type="checkbox"/> Rubella(German measles) | <input type="checkbox"/> Other: _____ |

Immunizations (Check ✓)

- | | | | |
|-----------------------------------|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> DPT | <input type="checkbox"/> Hemophilus influenza B | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Flu shot | <input type="checkbox"/> Tetanus Booster | <input type="checkbox"/> MMR | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Other: _____ | |

Please list (with approximate dates) any serious conditions, illnesses or injuries, and any hospitalizations.

Have you ever had a bad reaction to any medication? Y / N if yes, please explain _____

Your birth history (if known): premature forceps delivery prolonged labor C-section

Family History

Please indicate whether any of your family members have, or have had the following:

| | Relative | | Relative |
|------------------------|----------|---------------------|----------|
| Alcoholism | | Diabetes | |
| Allergies | | Drug abuse | |
| Alzheimer's disease | | Heart disease | |
| Arthritis | | High blood pressure | |
| Asthma | | Kidney disease | |
| Cancer (indicate type) | | Osteoporosis | |
| Depression | | Stroke | |
| Other mental illness | | Suicide | |



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MEDICATIONS

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

| Medication | Dose/day | How long? | Medication | Dose/day | How long? |
|------------|----------|-----------|------------|----------|-----------|
| 1. | | | 5. | | |
| 2. | | | 6. | | |
| 3. | | | 7. | | |
| 4. | | | 8. | | |

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

| Supplement | Dose/day | How long? | Supplement | Dose/day | How long? |
|------------|----------|-----------|------------|----------|-----------|
| 1. | | | 5. | | |
| 2. | | | 6. | | |
| 3. | | | 7. | | |
| 4. | | | 8. | | |

LIFESTYLE FACTORS

Please list any dietary restrictions _____

Please list all allergies (food, environmental, or medications).

Do you exercise? Y / N

What type of exercise and how often? _____

What do you do for recreation and relaxation? _____

Marital status: Single Married Divorced Partnership

Number of children: _____

Rate your stress level (circle): Low Average High Unbearable

Please **Check** ✓ any of the following that you use.

- | | |
|--|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Diet pills |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Laxatives |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> Sleeping pills |
| <input type="checkbox"/> Appetite suppressants | |



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WOMEN'S HEALTH

Do you get regular screening tests done by another doctor (blood work, Pap)? Y / N

Date of last Pap?(month/yr) ____/____

Have you ever had an abnormal Pap? Y / N

Age of first period? ____

Is your period regular? Y / N

Date of last period? ____

Length of monthly cycle (days)? ____

Average length of period or flow (days)? ____

Do you experience PMS? Y / N

Are you menopausal? Y / N. If yes, age of last period ____

Are you currently sexually active? Y / N

Have you been sexually active in the past? Y / N

Current forms of contraception? _____

Have you ever had a sexually transmitted disease? Y / N

Number of pregnancies? ____ Births? ____ Miscarriages? ____ Abortions? ____

Have you had a hysterectomy? Y / N

Have you had any of the following concerning your breasts?(circle)

Pain

Lumps

Infections

Cysts

Nipple discharge

Do you experience vaginal infections?

Never

Rarely

Frequently

Do you experience bladder infections?

Never

Rarely

Frequently

Any other female concerns not addressed:

MEN'S HEALTH

Do you get regular screening tests done by another doctor (blood work, prostate examination)? Y / N

Date of last prostate examination?(month/yr) ____/____

Are you currently sexually active? Y / N

Have you been sexually active in the past? Y / N

Current forms of contraception? _____

Do you have difficulty urinating completely? Y / N

How many times do you get up from your sleep to go to the bathroom at night? ____

Have you had any of the following?(circle)

Testicular pain

Hernia

STDs

Discharge

Sores

Do you have any sexual problems or concerns? Y / N. If yes, explain. _____



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REVIEW OF SYSTEMS

Please **check** if you are currently experiencing any of the following or write a **P** if you experienced it in the past.

General symptoms

- Headache
- Head injury
- Fever
- Chills
- Sweats
- Dizziness
- Fainting
- Loss of sleep
- Fatigue
- Nervousness
- Weight problems
- Numbness in arm/leg/hand
- Allergy
- Convulsions

Skin

- Hives or allergy
- Acne or skin eruptions
- Itching
- Bruises easily
- Dryness
- Boils
- Varicose veins
- Sensitive skin
- Change in mole

Kidneys & Reproduction

- Inability to control urine
- Frequent urination
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection
- Kidney stones
- Prostate trouble
- Sores on genitals

Eyes, Ears, Nose, Throat

- Dental decay
- Gum trouble
- Frequent colds
- Enlarged thyroid
- Tonsillitis
- Sore throat
- Hoarseness
- Enlarged glands
- Glaucoma
- Failing vision
- Cataracts
- Eye pain
- Ear discharge
- Loss of hearing
- Ear ache
- Nasal drainage
- Nose bleeds
- Nasal obstruction
- Sinus infection
- Hay fever

Musculoskeletal

- Neck pain
- Muscle weakness
- Swollen joints
- Leg Pain
- Foot/Hand pain
- Arm pain
- Hernia
- Low back pain
- Joint pain/stiffness
- Spinal curvature

Neurological

- Nervousness/Anxiety
- Convulsions
- Tingling/Numbness
- Depression
- Paralysis
- Confusion
- Fainting
- Forgetfulness

Cardiovascular

- Low blood pressure
- High blood pressure
- Previous heart stroke
- Hardening of the arteries
- Swelling of the ankles
- Poor circulation
- Paralytic stroke
- Irregular heart beat
- Shortness of breath
- Chest pain

Gastrointestinal

- Excessive thirst
- Poor/Excessive hunger
- Heartburn/Reflux
- Gas (flatulence)/Belching
- Nausea
- Vomiting
- Abdominal cramps
- Constipation
- Diarrhea
- Colon trouble
- Hemorrhoids
- Liver problems
- Gallbladder problems
- Jaundice
- Colitis

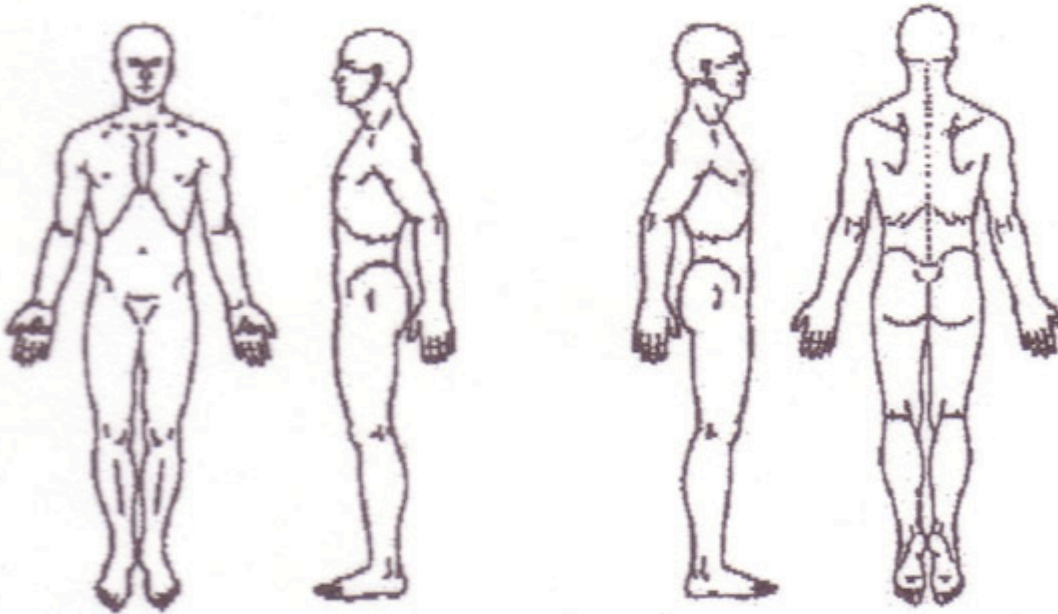
Respiratory

- Asthma
- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Difficult breathing



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Please circle any areas of symptoms or discomfort:



What are your treatment goals and expectations? _____

Is there anything else that you feel has not been covered? _____

Thank you very much for taking the time to complete this form.