Please be certain that all intake forms are completed and returned to AM Medical LLC prior to your appointment date. This information will be scanned into the electronic medical record. If more information needs added in sections below provide on a separate sheet.

# Personal Health History

**Name:** _____ **Date:** _____

**Date of Birth**_____ **Age** _____

What is the best contact phone #_____

Preferred Pharmacy (Name, location, phone#):

_____

**Primary Care Provider (if not joining our Primary Care practice)?**

_____

**Please list all physicians that you see. (Please include Mental Health Professionals)**

| Name | Address | Specialty, or condition that is being treated |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**What health issues do you want to focus on during this visit?**

| |
|---|
| |
| |
| |
| |

**Current Medical Problems (e.g. diabetes, heart disease, hypertension, etc.):**

| | | |
|---|---|---|
| 1. | 4. | 7. |
| 2. | 5. | 8. |
| 3. | 6. | 9. |

**Past Medical History:** List any major past illnesses, hospitalizations (include year or date if known).

| | Date | | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Past Surgical History: List any past surgeries (and what year/date).**

| | Date | | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Past Gyn/Obstetrical History:** List any past pregnancies.

| | | | |
|---|---|---|---|
| Vaginal Births | | Miscarriage/ Still births | |
| Caesarian Sections | | Pregnancy Terminations | |
| Abnormal PAP tests | | Other GYN Procedures | |

**Family History:** Have your close relatives (parent, brother or sister, child, grandparent) had the following?

| | Yes | No | If yes, which relative | Age at Diagnosis |
|---|---|---|---|---|
| Heart attack, angina | ☐ | ☐ | | |
| Stroke | ☐ | ☐ | | |
| High blood pressure | ☐ | ☐ | | |
| High Cholesterol | ☐ | ☐ | | |
| Diabetes | ☐ | ☐ | | |
| Thyroid disease | ☐ | ☐ | | |
| Breast cancer | ☐ | ☐ | | |
| Other Cancer--what type? | ☐ | ☐ | | |
| Kidney Disease | ☐ | ☐ | | |

| | | | | |
|---|---|---|---|---|
| Osteoporosis | ☐ | ☐ | | |
| Rheumatoid Arthritis | ☐ | ☐ | | |
| Asthma | ☐ | ☐ | | |
| Mental Health disorder | ☐ | ☐ | | |
| Substance Abuse | ☐ | ☐ | | |

## Pharmaceuticals and Supplements:

**Do you have Medication allergies?** Yes No If yes, please list:

| Medication | Reaction | Medication | Reaction |
|---|---|---|---|
| | | | |
| | | | |

**Please list all prescribed and over-the-counter medications you take regularly**. ***Please include all supplements, vitamins or herbal products.***

| Medicine/ Supplement including Dose | Frequency | Dose | Frequency |
|---|---|---|---|
| 1. | | 8. | |
| 2. | | 9. | |
| 3. | | 10. | |
| 4. | | 11. | |
| 5. | | 12. | |
| 6. | | 13. | |
| 7. | | 14. | |

**Please outline your use of the following, past or present:**

| Product: | Current Use? Yes/No | Quantity Per Day | Quantity Per Week | Past Use? Yes/No | Do others have concern about your usage? |
|---|---|---|---|---|---|
| Tobacco | | | | | |
| Alcohol | | | | | |
| Recreational Drugs | | | | | |
| Caffeine: | | | | | |

## Preventive Health: Please provide the dates and documentation when possible

**Do you routinely wear a seat belt?** ☐ Yes ☐ No

| | Date |
|---|---|
| Pap/pelvic exam (females) | |
| Mammogram (females) | |
| Colonoscopy | |

| | |
|---|---|
| Test of stool for blood (Stool Guaiac) | |
| Bone Density (Dexa) | |
| Eye exam | |
| Cardiovascular stress test | |

**Review of Symptoms:** Please check no or yes for the following **current** symptoms (**within past 3 months**)

| GENERAL | Yes | No | | GASTROINTESTINAL | Yes | No |
|---|---|---|---|---|---|---|
| Fever | ☐ | ☐ | | Diarrhea/Constipation | ☐ | ☐ |
| Sweats at night | ☐ | ☐ | | Indigestion/heartburn | ☐ | ☐ |
| Hot flashes | ☐ | ☐ | | Nausea | ☐ | ☐ |
| Temperature intolerance | ☐ | ☐ | | Blood in stool | ☐ | ☐ |
| Excessive thirst | ☐ | ☐ | | **GENITOURINARY** | | |
| Fatigue | ☐ | ☐ | | Pain or burning on urination | ☐ | ☐ |
| Sleep difficulties | ☐ | ☐ | | Frequent urination | ☐ | ☐ |
| Daytime sleepiness | ☐ | ☐ | | Waking to urinate more than once at night | ☐ | ☐ |
| Unplanned weight change | ☐ | ☐ | | Excessive urination | ☐ | ☐ |
| **SKIN** | | | | Difficulty emptying bladder | ☐ | ☐ |
| Rash | ☐ | ☐ | | Urinary incontinence | ☐ | ☐ |
| New or changing moles | ☐ | ☐ | | **Women:** | | |
| **EYES** | | | | Heavy vaginal discharge | ☐ | ☐ |
| Pain | ☐ | ☐ | | Heavy menstrual bleeding | ☐ | ☐ |
| Redness | ☐ | ☐ | | Painful menstrual periods | ☐ | ☐ |
| Vision change | ☐ | ☐ | | Irregular menstrual bleeding | ☐ | ☐ |
| **EAR, NOSE, THROAT** | | | | **MUSCULOSKELETAL** | | |
| Hearing loss | ☐ | ☐ | | Generalized or all-over pain | ☐ | ☐ |
| Ringing in ears | ☐ | ☐ | | Joint pain | ☐ | ☐ |
| Dizziness or vertigo | ☐ | ☐ | | Stiffness | ☐ | ☐ |
| Bleeding gums | ☐ | ☐ | | Joint swelling | ☐ | ☐ |
| Nosebleeds | ☐ | ☐ | | Joint redness | ☐ | ☐ |
| **BREAST** | | | | Back or neck pain | ☐ | ☐ |
| Breast Pain | ☐ | ☐ | | **NEUROLOGICAL** | | |
| Masses and or Lumps | ☐ | ☐ | | Abnormal gait (Trouble Walking) or falls | ☐ | ☐ |
| Nipple discharge | ☐ | ☐ | | Headache severe and/or frequent | ☐ | ☐ |
| Skin changes | ☐ | ☐ | | Seizures | ☐ | ☐ |
| **CARDIOVASCULAR** | | | | Muscle weakness, TIA or stroke | ☐ | ☐ |
| Chest pain | ☐ | ☐ | | Fainting or loss of consciousness | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | | Localized numbness, tingling, neuropathy | ☐ | ☐ |
| Irregular heart beat (palpitations) | ☐ | ☐ | | **PSYCHOLOGICAL** | | |
| Leg swelling or edema | ☐ | ☐ | | Anxiety | ☐ | ☐ |
| **PULMONARY** | | | | Depression | ☐ | ☐ |
| Wheezing or shortness of breath | ☐ | ☐ | | Memory loss | ☐ | ☐ |
| Chronic cough | ☐ | ☐ | | Mood swings | ☐ | ☐ |
| **HEMATOPOIETIC** | | | | | | |
| Swollen lymph glands | ☐ | ☐ | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Blood clots | ☐ | ☐ | | | | |
| Excessive bleeding | ☐ | ☐ | | | | |
| Anemia | ☐ | ☐ | | | | |
| | | | | | | |
| | | | | | | |

**Movement, Exercise and Rest:**

What forms of exercise and movement do you enjoy?

_____

**Please describe your usual physical activity**

| Activity | How often | How long each time |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

How many hours of sleep do you usually get each night? _____

Describe any issues you have with sleep._____

_____

**Nutrition:** Please list any food allergies or sensitivities:

| Foods | Reaction | Foods | Reaction |
|---|---|---|---|
| | | | |
| | | | |

Do you currently or have you ever had a problem with weight or eating? ☐ Yes ☐ No

If yes, please describe:

_____

Are you comfortable with your relationship with food? ☐ Yes ☐ No

Do you feel knowledgeable about your nutritional needs? ☐ Yes ☐ No

Who prepares your meals?

_____

**Personal and Professional Development:**

Current or past occupation:

_____

☐ Retired? ☐ Working at home? ☐ Care-taking? ☐ Disabled? ☐ Unemployed?

Are you happy with your occupation? ☐ Yes ☐ No

Why? _____

_____

Do you anticipate any work changes in the near future? Retirement, etc.

_____ _____

Do you have a Racial/Culture heritage that is important to you?

**Relationships**:
Relationship status: _____ if married or partnered, what is your relationship length? _____
What are your living arrangements? _____ Number of children and ages: _____
Are you sexually active? ☐ Yes ☐ No are you happy with your sexual life? _____
Which relationship(s) fulfill and/or empower you? _____
Who or what drains your energy? _____

**Physical Environment:** Do you have specific health concerns about your current home or environment
_____

Have you had hazardous environmental or occupational exposures? If yes, please describe.
_____

**Spirituality:**
What things or activities bring you your greatest joy and meaning? What inspires you?
_____
_____

What things create the greatest challenges for you? _____
_____

What makes you feel connected to the larger world? -Describe your spiritual or religious practices if any (i.e., meditation, prayer, time in nature, worship attendance, etc.)._____
_____

If time and money were not an issue, describe the things you long to do in your life._____
_____

**Mind-Body Connection:**
Rate the amount of stress in your life: ☐ None ☐ A Little Bit ☐ Moderate ☐ Quite a Lot ☐ Extreme How well do you manage stress? ☐ Not at All ☐ A Little Bit ☐ Moderate ☐ Quite well ☐ Excellent
What are the main sources of stress in life? (Personal, professional, financial etc.) _____
_____
What are your methods of coping with the stress in your life? _____
_____

**What are your health goals?** What are your overall goals for improving your health and your life? ___
_____
_____

Is there anything else that would be helpful for us to know about you?

_____