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?

_____