

Wholesome Family Medicine

4036 S. 6th St. Ste. #2 Klamath Falls, OR 97603

Phone: (541) 851-9320 Fax: (541) 851-9322

Adult New Patient Intake

Name: _____
Last First M.I.

Date of Birth: _____ Age: _____ Gender: F M _____

Marital Status: Married Single Divorced Domestic Partnership

Name and address of Dr's office/hospital/clinic where your records are kept:

Office/Hospital/Clinic Name Street/ P.O. Box

City State Zip Code

Contact Information:

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Please circle the preferred number to contact you:

Home #: _____ Work #: _____ Cell #: _____

E-mail: _____

Emergency Contact: _____ Phone: _____

Insurance Provider: _____

Verification of Naturopathic Coverage?: _____

How did you hear about Dr. Blevins?: _____

Anyone you want to designate that we may share your medical information with? This includes scheduling, lab results, diagnosis, recommendations etc.? This will remain in effect until rescinded in writing.

Name: _____ Relation: _____

ALL RESPONSES WILL BE KEPT CONFIDENTIAL

What are your top four health goals?

- | | |
|----------|----------|
| 1) _____ | 3) _____ |
| 2) _____ | 4) _____ |

MEDICATIONS

Do you have any drug allergies? If yes, please list drug along with reaction: _____

Please list all medications and supplements (with doses) currently being taken. Please bring all bottles with you to your appointment.

MEDICAL HISTORY

Please list all medical diagnoses with initial dates below:

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Additional: _____

Imaging and Special Studies

When

Where

Results

X-ray: _____

MRI: _____

CT Scan: _____

Other: _____

INJURIES/SURGERIES/HOSPITALIZATIONS

IMMUNIZATIONS

Any adverse reactions to immunizations? (Please specify)

DIET

Do you have any food intolerances that you know of? Yes _____ No _____

If yes, please explain: _____

SYMPTOMS

Please circle: Y=current condition N=never had P=had in the past

| | | | | | |
|---------------------------|-------|-------------------------------|-------|---------------------------|-------|
| <i>Skin issue</i> | Y P N | <i>Gas/bloating</i> | Y P N | <i>Bloody urine</i> | Y P N |
| <i>Infection</i> | Y P N | <i>Heartburn</i> | Y P N | <i>Anxiety</i> | Y P N |
| <i>Bleeding gums</i> | Y P N | <i>Belching</i> | Y P N | <i>Depression</i> | Y P N |
| <i>Nose bleeds</i> | Y P N | <i>Nausea/Vomiting</i> | Y P N | <i>Sleep problems</i> | Y P N |
| <i>Headaches</i> | Y P N | <i>Anemia</i> | Y P N | <i>Night sweats</i> | Y P N |
| <i>Dizziness</i> | Y P N | <i>Urinary issues</i> | Y P N | <i>Sensitive to light</i> | Y P N |
| <i>Change in vision</i> | Y P N | <i>Libido issues</i> | Y P N | <i>Body/Breath odor</i> | Y P N |
| <i>Hearing loss</i> | Y P N | <i>Easy bruising</i> | Y P N | <i>Sinus infections</i> | Y P N |
| <i>Sore throat</i> | Y P N | <i>Flat feet</i> | Y P N | <i>No appetite</i> | Y P N |
| <i>Runny nose</i> | Y P N | <i>Back pain</i> | Y P N | <i>Nightmares</i> | Y P N |
| <i>Trouble swallowing</i> | Y P N | <i>Canker sores</i> | Y P N | <i>Wheezing</i> | Y P N |
| <i>Stomach pain</i> | Y P N | <i>Cough</i> | Y P N | <i>Fever</i> | Y P N |
| <i>Diarrhea</i> | Y P N | <i>Unintended weight loss</i> | Y P N | <i>Frequent colds</i> | Y P N |
| <i>Constipation</i> | Y P N | <i>Bleeding tendency</i> | Y P N | <i>Excessive fatigue</i> | Y P N |

Do you have any other condition not mentioned? _____

FAMILY HISTORY (Y or N)

____ *Heart Disease* ____ *Diabetes* ____ *Birth defect* ____ *Cancer* ____ *Mental Illness*
____ *Hypertension* ____ *Arthritis* ____ *Tuberculosis* ____ *Allergies* ____ *Hay fever*
____ *Eczema* ____ *Other (please explain)* _____

Women:

Age of first menses: _____ Cycle length (days): _____ PMS?: _____
Date of last Pap: _____ Any history of abnormal Pap results?: _____
Any concerning symptoms with menses?: _____
Hysterectomy? ____ Complete/Partial? _____ Year: _____ Reasona: _____

Is there anything else relevant to your health that you feel would be helpful to share?: