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 Wholesome Family Medicine?: _____

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 This will remain in effect until rescinded in writing.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

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