New Patient Health Record

At Vitality Medical Clinic, Dr. Tami takes the time to learn all about your health history and help you achieve optimal health. Please complete and return this **Patient Health History form** to tell us important information about you.

Please call our office and schedule a new patient appointment *before* you fill out and submit this questionnaire.

Return your completed form to us at least 48 HOURS before your first appointment.

How to complete and return this form to us (if completing electronically):

1. Complete the form using Microsoft Word. Save the file with a new filename that includes **your name** (e.g., "*New-Patient-Health-Record-MarySmith.doc*"). (NOTE: Please leave the document in MSWord *.doc* format; do not convert it to another format such as PDF or HTML.)
2. Return the form to us as an attachment in **email**. In your email program, open a new message and attach the MSWord file.
   In the Subject field of the email window, write: **New Patient Health Record**
   Send email to: **info@vitalitymedispa.net**.

NOTE: If you are unable to send this form in email, please print your completed form and mail it to our office at the address below. ****Be sure to mail it at least 5 days before your appointment so we receive it 24-48 hours in advance**.

If you have any questions, please call us at **206. 622.5300**. Our fax is **206. 622.5301**
Thank you and we look forward to working with you!

New Patient Health Record

New Patient Appointment Date: ___________________ Time: ________________ Today's Date: ___________________

Patient's Information

Name ____

Prefer to be called ______________________________

Spouse/Partner_________________________________

Address ______________________________________

City _________________ State______ Zip ________

Home Phone __________________________________

Work Phone __________________________________

E-mail Address ________________________________

Birth Date ____________________ Age ____ ______

Gender: ☐ Female ☐ Male

Marital Status: ☐ Married ☐ Partnered ☐ Single
☐ Divorced ☐ Widowed ☐ Separated

General Information

Do you have a Primary Care Doctor? ☐ No ☐ Yes

Physician's name: _______________________________

Physician's Contact Number: _____________________

Have you consulted a doctor about your current condition(s)? ☐ No ☐ Yes

Please state diagnosis, therapy and the results:

____

____

____

____

Account Information

Person responsible for the account _______________ ___

Occupation ______________________________________

Employer ____

Business Address _________________________________

City ____________________ State ___Zip __________

Business Phone ___________________________________

Person to Contact in Case of Emergency

Name ____

Relationship ______________________________________

Address ____

City ____________________ State ___ Zip __________

Telephone ____

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Authorization for Treatment

I, the undersigned, hereby authorize the doctor to perform diagnostic tests deemed necessary for my care and to perform any and all forms of treatment, medication, and therapy that are indicated and are in accordance with the Standards of Naturopathic and Anti-Aging Medical Care.

Patient's Signature ______________________________ Date ______________________

Personal History

Patient's Name ______________________________ Date ______________________

Number of Children ______ Names & Ages ______________________________

Current Health Condition

(Please list your present health problems and concerns.)

Problem or Concern	Date of Onset
1.	
2.	
3.	
4.	
5.	

Please list the most significant, stressful events in your life, from the most recent to the most distant.
Are any of these situations continuing to impact your life? If so, please indicate these clearly.

Event	Continuing?
	☐ Continuing
	☐ Continuing
	☐ Continuing
	☐ Continuing

Family Medical History

From the following list, please write next to each family member all conditions that apply.

Conditions	
AIDS	HIV+
Alcoholism	Kidney disorder
Allergies	Mental illness
Anemia	Migraines
Arthritis	Obesity
Asthma	Osteoporosis
Breast Cancer	Psoriasis
Cervical Cancer	Senility
Ovarian Cancer	Seizures
Prostate Cancer	Sexually Transmitted Disease
Uterine Cancer	Skin problems
Other Cancers (list types)	Stroke
Diabetes	Suicide
Eczema	TB
Gout	Thyroid problems
Heart Disease	Ulcer
Hemophilia	Other
High blood pressure	

Family members affected
Mother:
Father:
(Maternal) Grandparents:
(Paternal) Grandparents:
Siblings:
Other Family:

Name ______________________________ Date ______________________

Medications and Hospitalizations

Please include all your current **prescription medications** (sleeping pills, birth controls pills), **non-prescription medications** (aspirin, antacids, laxatives, antihistamines), vitamins, minerals, herbs, etc. (**Include dose for each**.)
Attach a separate sheet, if necessary.

Medication	Dose per day	Reason for use	Prescriber	Date started Med.
Hospitalization, surgeries or serious injuries (dates and types of illness or operation):				

Allergies

Drugs, food or other substances	Reaction

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Name ______________________________ Date ____________________

Health Data

(Please fill in completely)

Exam	Date	Result	Due	Screening Recommendations
Last Pap Smear/Gynecologic Exam				Yearly starting after first intercourse or age 21
Mammogram				Yearly starting at age 40
Bone Density Test (DEXA)				Every 2 years starting at age 50
Colonoscopy				Every 10 years starting at age 50
Prostate and Testicular Exam				Yearly for men starting at age 40
Other	**Date**	**Location**	**Result**	
Physical Exam				
Foreign Travel History & Immunizations				
Tuberculosis (TB) skin test				
Diagnostic Imaging (X-Ray, Ultrasound, MRI, CT, Angiogram, etc.)				
Other				

Health History

Please CHECK any conditions you **currently have** or **have had in the past year ONLY**.

General	Gastrointestinal	Eye/Ear/Nose/Throat	Cardiovascular
☐ Chills	☐ Poor Appetite	☐ Bleeding gums	☐ Chest pain/pressure
☐ Depression	☐ Bloating	☐ Blurred vision	☐ High blood pressure
☐ Dizziness	☐ Bowel changes	☐ Crosses eyes	☐ Irregular heart beats
☐ Fainting	☐ Constipation <1 stool/day	☐ Difficulty of swallowing	☐ Low blood pressure
☐ Fever	☐ Diarrhea	☐ Double vision	☐ Poor circulation
☐ Forgetfulness	☐ Excessive hunger	☐ Ear ache	☐ Rapid heart beat
☐ Headache	☐ Excessive thirst	☐ Ear discharge	☐ Varicose veins
☐ Loss of sleep	☐ Gas	☐ Hay fever	☐ Edema
☐ Nervousness	☐ Hemorrhoids	☐ Hoarseness	
☐ Numbness	☐ Indigestion	☐ Loss of hearing	
☐ Sweats	☐ Nausea	☐ Nosebleeds	
	☐ Rectal bleeding	☐ Ringing in the ears	
	☐ Stomach pain	☐ Sinus infections	
	☐ Vomiting	☐ Vision “flashes”	
	☐ Vomiting blood	☐ Vision “halos”	
	☐ Parasites		

Name ______________________________ Date ______________________

Health History (continued)

Please CHECK any conditions you **currently have** or **have had in the past year ONLY**.

Respiratory	Skin	Muscle/Joint/Bone	Genito-Urinary
☐ Shortness of breath	☐ Acne	Pain, weakness, or numbness in:	☐ Blood in the urine
☐ Persistent cough	☐ Bruise easily	☐ Arms	☐ Frequent urination
☐ Wheezing	☐ Itching	☐ Back	☐ Lack of bladder control
☐ Cough with blood	☐ Change in mole(s)	☐ Feet	☐ Painful urination
	☐ Rash	☐ Hands	
	☐ Scars	☐ Hips	
	☐ Sore that won't heal	☐ Legs	
		☐ Neck	
		☐ Shoulders	
		☐ Loss of height	

Please CHECK any conditions you **currently have** or **have ever had**.

☐ AIDS	☐ Frequent antibiotic use	☐ Panic attacks
☐ Alcoholism	☐ Hay fever	☐ Parasites
☐ Allergies	☐ Headaches	☐ Pneumonia
☐ Anemia	☐ Hemorrhoids	☐ Prostate problems
☐ Anorexia	☐ Hemophilia	☐ Psoriasis
☐ Appendicitis	☐ Problems with gums and teeth	☐ Psychiatric care
☐ Arthritis	☐ Gall bladder problems	☐ Rheumatic fever
☐ Asthma	☐ Glaucoma	☐ Spontaneous abortion (miscarriage)
☐ Bladder/urinary problems	☐ Goiter	☐ Seizures
☐ Bleeding disorders	☐ Gout	☐ Sexual abuse
☐ Breast lump	☐ Hair falling out	☐ Sinusitis
☐ Bronchitis	☐ Heart Disease	☐ Skin problems
☐ Bulimia	☐ Hernia	☐ Stroke
☐ Cataracts	☐ High Cholesterol	☐ Suicidal attempt
☐ Cancer (list type)	☐ Hypoglycemia	☐ Thyroid problems
☐ Chemical dependency	☐ Irritable bowel/colitis	☐ Tonsillitis
☐ Diabetes	☐ Jaundice	☐ Ulcers
☐ Digestive disorders	☐ Joint problems	☐ Varicose veins
☐ Ear problems	☐ Kidney disease	☐ Vaginal infections
☐ Edema, dropsy or water weight	☐ Liver disease	
☐ Eczema	☐ Lung problems	☐ Other:
☐ Emphysema	☐ Migraine headaches	
☐ Epilepsy	☐ Multiple sclerosis	
☐ Eye problems	☐ Obesity	
☐ Fatigue (chronic)	☐ Osteoporosis	
☐ Female gynecological problems	☐ Pacemaker	

Name ____ Date ________________________________

Health History (continued)

Please CHECK any conditions you **currently have** or **have ever had**.

Infectious diseases:		
☐ Chicken pox	☐ Measles	☐ Scarlet fever
☐ Chlamydia	☐ Mumps	☐ Syphilis
☐ Gonorrhea	☐ Mononucleosis/Epstein-Barr	☐ Tuberculosis
☐ Hepatitis	☐ Polio	☐ Typhoid fever
☐ Herpes	☐ Papilloma virus	☐ Other:
☐ HIV positive	☐ Rubella	

Please CHECK Yes or No for any conditions you **currently have** or **have ever had**.

Yes	**No**	Breast/Prostate cancer
Yes	**No**	Uterine/Cervical cancer
Yes	**No**	Currently pregnant
Yes	**No**	Currently breastfeeding
Yes	**No**	Heart or Liver or Kidney disease
Yes	**No**	Thrombophlebitis (deep vein pain/clotting issue)
Yes	**No**	Thromboembolic disorder (blood clotting problem)
Yes	**No**	Estrogen-related cancer
Yes	**No**	Undiagnosed abnormal genital bleeding
Yes	**No**	Family history of Breast cancer
Yes	**No**	Family history of Uterine cancer or Cervical cancer or Prostate cancer
Yes	**No**	Breast cysts, breast nodules, fibrocystic breasts, abnormal mammogram
Yes	**No**	Severe liver disease
Yes	**No**	History of severe hypersensitivity to drugs
Yes	**No**	Genital cancer (Vaginal or Testicular cancer)
Yes	**No**	Use of blood thinning medications
Yes	**No**	Severe reaction to estrogen or progesterone or testosterone or DHEA or Cortisol
Yes	**No**	Currently active cancer
Yes	**No**	Myocardial infarction or other acute heart disease
Yes	**No**	High blood pressure or intracranial hypertension
Yes	**No**	BPH (Benign Prostatic Hypertrophy) causing obstructed urine flow

If you answered **Yes** to any of the above, please describe in detail.

Name ____ Date ____________________________

Hormone Medication History

Please complete the following table, using the examples below.

Hormone	DHEA	Progesterone	Estrogen	Testosterone
Hormone Name				
Dosage				
Date Started				
Date Ended				
Using Currently				
Days of month used				
Natural				
Synthetic				
Cream				
Suppository				
Caps/Tablets				
Drops				

Reason for use:
List reactions to hormones:

EXAMPLE:

Hormone	DHEA	Progesterone	Estrogen	Testosterone
Hormone Name		Prometrium	Estradiol	
Dosage		150 mg	2,5 mg	
Date Started		6/05	6/05	
Date Ended				
Using Currently	No	Yes	Yes	No
Days of month used		Days 11-25	Days 1-25	
Natural				
Pharmaceutical		Yes	Yes	
Cream				
Suppository				
Caps/Tablets		Yes	Yes	
Drops				

Name ______________________ Date ______________________

Personal Health Habits

Height:	Current Weight (lbs):		1 Year Ago (lbs):	Max. Weight (lbs):	Date:
Item	**No**	**Yes**	**Details**		
Tobacco Use			Smoke or Chew: Years:	Amt Per Day:	Year Quit:
Alcohol Use			Type:	Drinks per week:	
Rec. Drug Use			Type:	Frequency:	
Coffee:			Cups Per Day:	Caffeinated or Decaf:	
Tea			Cups Per Day:	Caffeinated or Decaf:	
Sodas			Type:	Cans Per Day:	
Chocolate			How Often:		
Exercise			Type:	Frequency:	Duration:

Occupational and Household Exposure

What is your occupation?				Average hours you work per week:
Please describe your work:				
Situation	**No**	**At Times**	**Yes**	**Details**
Do you work in the presence of toxic fumes or chemicals?				
Have you ever worked near toxins?				If yes, please provide details:
Are you exposed to second-hand smoke?				
Do any of your hobbies involve toxic materials?				If yes, what kind (paints, plastics, gases, lead, etc.):
Do you wear sunglasses, contact lenses, or glasses when outside?				
Do you have house pets?				Type:

Detoxification

Situation	No	At Times	Yes	Details
Have you ever participated in a detox program supervised by a qualified health professional?				If yes, please explain:
Do you fast?				
Do you feel well rested on waking in the morning (ready to get up and going)?				
How many hours do you sleep on the average night:				
On a scale from 1 to 10, how do you rate the quality of your sleep? (0 = no sleep and 10 is great):				

Name ____ Date ______________________________

Digestion and Eating Habits

Description of diet	No	At Times	Yes	Details (Describe each meal below)
Do you eat **breakfast**?				
Do you eat **lunch**?				
Do you eat **dinner**?				
Do you eat **snacks**?				Number of times a day: What do you eat?:
Do you diet often?				
Are you on a special diet?				If yes, describe:
What kind of foods do you **crave**?	List:			
What kinds of foods cause you **problems**?	Describe the food and the problem you experience when you eat it:			
What foods do you eat every day?				
Do you often eat at fast-food restaurants?				
Do you often eat in restaurants?				
Do you use NutriSweet (aspartame) or other artificial sweeteners?				
How do your bowel movements tend to be?	☐ Constipated ☐ Loose ☐ IBS ☐ IBD ☐ _________			

Skin

Do you perspire when you exercise? ☐ Lightly ☐ Moderately ☐ Heavily
Do you perspire other than when exercising? ☐ No ☐ At Times ☐ Yes When?
Do you have difficulty perspiring? ☐ No ☐ At Times ☐ Yes
Does your perspiration smell strong? ☐ No ☐ At Times ☐ Yes Does it smell like urine? ☐ No ☐ At Times ☐ Yes

Life Style Index

Please rate your level of functioning for each area of you life on a scale of 1-10 (10 = best)

Function	Rating	Function	Rating	Function	Rating
Mental		Family		Social	
Emotional		Creativity		Spiritual	
Physical		Fun		Career	

Name ______________________________ Date ______________________

Vitality Survey

Scoring: Never —0 Seldom — I Occasionally —2 Often —3 Very Often —4

How often do you…	**Score**
Lose your sense of humor/take life too seriously?	
Experience doubt or indecision?	
Experience worry and anxiety?	
Feel over-cautious or pessimistic?	
Lack self confidence or feel low self-esteem? -	
Experience stress or feel nervous or tense?	
Feel irritable or oversensitive?	
Experience difficulty concentrating and loss of clear thought?	
Experience inadequate energy (fatigue)?	
Have coffee, tea, tobacco, sugar or other stimulants as a pick up?	
Experience nervous indigestion?	
Experience loss of sex drive?	
Experience difficulty sleeping?	
Experience difficulty getting up in the morning?	
Feel run down?	
Feel depressed?	
Feel like crying for no reason?	
Find it difficult to sit quietly (without fidgeting, talking, reading, watching TV, etc.)?	
Find it difficult to express your feelings?	
Experience rapid heart beat or panic? -.	
Feel moody?	
Feel suicidal or wonder whether life is worth living?	
Have anxiety about not having enough money?	
Fear ill health?	
Fear criticism?	
Fear loss of love?	
Fear old age or death?	
Feel “something is the matter with me” but don’t know what?	
Think that you might be going crazy (losing it)?	
TOTAL SCORE:	

0 — 30 POINTS = Powerful Nerve Force HIGH VITALITY 31— 45 POINTS = Strong Nerve Force GOOD VITALITY 46 — 60 POINTS = Moderate Nerve Force AVERAGE VITALITY 61 — 75 POINTS = Low Nerve Force LOW VITALITY	76 — 90 POINTS = Nervous Fatigue NERVOUS FATIGUE 91 — 105 POINTS = Nervous Depletion NERVOUS EXHAUSTION 106 — 120 POINTS = Serious Nervous Exhaustion SEVERE BURNOUT

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Name ____ Date ______________________________

Women Only

Gynecologic History	Yes	No	Details
Age your period began:			**Abnormal Pap smear? Date:**
Menopause			If yes, date of last period:
Perimenopause			If yes, describe symptoms:
Ovaries removed (one/both)			If yes, when:
Uterus removed			If yes, when:
DES – did your mother take it during pregnancy?			
Are you still menstruating?			**If yes, complete the section below; if no, skip that section**

Menstruation	Yes	No		Yes	No
Regular periods			Bleeding between periods		
Irregular menses Symptoms:			Spotting		
Cramps / # of days: Mild___ moderate___ severe____			Midcycle spotting		
PMS / # of days: Symptoms:			Spotting instead of period		
Oral contraceptives (past/present)			Weight gain (how many lbs)		
Periods every _____days (length of cycle) Duration: _____ days (flow days) Flow: heavy__ medium___ light___					
Date your last 6 periods began: _____ _______ _______ _______ _______ _____					

Pelvic Exam	
Date of last pelvic exam:	Performed by:
Date of last PAP smear:	Result:
Recurrent vaginal yeast infections Yes____ No ____	Are you sexually active: Yes____ No ______

Breast Health	Yes	No		Yes	No
Breast pain			Fibrocystic breast disease		
Breast lumps			Do you perform monthly breast exam on yourself?		
History of abnormal mammogram			Currently breastfeeding		
Nipple discharge			Breast implants / Type:		
Date of last mammogram:			**Results:** **Location of diagnostic center:**		

Pregnancy	Yes	No		Yes	No
Currently pregnant			Planning pregnancy (If yes, when:)		
Desire pregnancy			Pregnancy complications (If yes, describe)		
Prior pregnancies: #___ Births #___ C-Sections #__ Miscarriages #___ Abortions #____					

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Name ____ Date _________________________________

Female Hormone Imbalance Rating

Please rate the severity of the symptom(s) or condition **if it's present** by rating it on a **Wellness Gauge Scale 0 to 10 when 0 = symptom is not present ☺ and 10 = symptom is severe ☹**

	Abdominal pain		Fibroids		Mood swings
	Allergies		Fluid retention		Night sweats
	Anger easily		Food cravings/binge eating		Ovarian cyst(s)
	Back pain		Heavy menstrual bleeding		PMS
	Bloating		Vaginal dryness		Rheumatoid arthritis
	Chronic stress		Hot flashes		Skin problems
	Depression		Insomnia		Spotting
	Disinterest in sex/low sex drive		Irregular menstrual cycle		Subfertility
	Endometriosis		Irritable or anxious		Other:
	Fatigue		Meat eater (rate frequency)		
	Fibrocystic breast disease		Menstrual migraines		
				TOTAL SCORE:	

Past or Present Condition (0 = none, 10 = yes)

	Ovarian Cancer		Infertility (never able to conceive)
	Uterine Cancer		Loss of height/ bone loss
	Cervical Cancer		Miscarriage
	Breast Cancer		Premature menopause (<45 yrs old)
	Estrogen/Progesterone sensitive Cancer		Pain with intercourse
			TOTAL SCORE:
			GRAND TOTAL SCORE:

Are you completely satisfied with your sexual experience: Yes____ No ____
Please explain:

Name ______________________________ Date ______________________

Men Only

	Yes	No		Yes	No
Breast lump			DES – did your mother take it during pregnancy?		
Lump in testicle			Date of last genital exam:		
Penis discharge			Date of last prostate exam:		
Sore on the penis			Date of last PSA test: Result:		
Erection difficulties					

Male Hormone Imbalance Rating

Please rate the severity of the symptom(s) or condition **when it's present** by rating it on a **Wellness Gauge Scale 0 to 10, when 0= symptom is not present ☺, 10= symptom is severe ☹**

	Abdominal pain		Thinning armpit, head, pubic hair		Urine flow dribbling at the end
	Joint pain/Stiffness		Skin problems/dryness		Blood in urine
	Anger easily		Excessive sweating (day or night)		Urinary incontinence
	Back pain		Mood swings		Pain with urination
	Rheumatoid arthritis		Lack interest in leisure/social activities		Pain with ejaculation
	Chronic stress		Low stamina		Bloody ejaculation
	Depression		Difficulty obtaining erection		Pain with intercourse
	Disinterest in sex/low sex drive		Difficulty maintaining erection		Unable to conceive (subfertility)
	Erectile dysfunction		Pain with erection		Mass in genital organs
	Fatigue		Lack of nocturnal erections		Heavy drinking (past/ present)
	Insomnia		Lack of morning erections		Frequent urination
	Irritable or anxious		Urine flow slow to start		Other:
	Food cravings/binge eating		Weak urine stream		
	Breast enlargement		Unable to void bladder completely		
					TOTAL SCORE:

Past or Present Condition (0 = none, 10 = yes)

	History of mumps infection		Infertility (never able to conceive)
	History of mass in genitalia		Loss of height/bone loss
	History of testicular/scrotal surgery		Cancer: (list type)
	Developmental issues w/sex organs		Other:
	Family history of prostate cancer		**TOTAL SCORE:**
			GRAND TOTAL SCORE:

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