Innate
MEDICINE

Name:_____

Appointment Date:_____

New Patient Medical History

Concerns *(please rank by priority)* Onset Frequency Severity
Example: Headaches *2012* *3-times/week* *mild/mod/severe*

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

What are your goals for this visit? _____

_____

_____

Medical conditions (past or present) *Example: diabetes, high blood pressure, breast cancer*

What	When	What	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgical Procedures & Injuries

Describe	Date	Describe	Date
_____	_____	_____	_____
_____	_____	_____	_____

Are there specific diseases that run in your immediate family?

Disease	Family Member	Disease	Family Member
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What medications are you taking now? (include prescription and over-the-counter drugs)

Medication	Reason	When started	Dosage per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What vitamins/minerals/supplements are you taking now?

Name and manufacturer *Ex: St John's wort (Nature's Way)*		Reason *feeling down*	When started *2 months ago*	Dosage/day *3 caps*
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

Allergies/Sensitivities	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Tobacco Yes No Type & frequency _____

Alcohol Yes No #drinks _____ per day/week/month *(circle one)*

Other drugs Yes No Type & frequency _____

Coffee, Cola or other caffeine beverages? Yes No Type & frequency _____

Women's Health

Age at first menstrual cycle_____ Date of last menstrual cycle_____

Date of last Pap_____ Mammogram_____ Pelvic exam_____

Number of pregnancies_____ Births_____ Miscarriages_____

Review of Systems

Problem		System	Describe
Yes	No	chest pain, high blood pressure, fainting	_____
Yes	No	shortness of breath, wheezing, difficulty taking a deep breath	_____
Yes	No	thyroid, abnl blood sugars, energy level, too hot or too cold	_____
Yes	No	headaches, numbness, dizziness, weakness	_____
Yes	No	constipation/diarrhea, difficulty digesting, heartburn	_____
Yes	No	rashes, itchiness, dryness	_____
Yes	No	joint pain, muscle pain or spasm	_____
Yes	No	hearing, sinus congestion, allergy	_____
Yes	No	blurred, seeing double or spots	_____
Yes	No	fever, night sweats, weight loss/gain	_____
Yes	No	difficulty sleeping	_____
Yes	No	anxious, depressed, stressed	_____
Yes	No	low libido, impotence	_____

Please describe your typical diet:

Breakfast _____

AM Snack _____

Lunch _____

PM Snack _____

Dinner _____

Night Snack_____

Do you often skip meals? _____ If yes, which one(s)? _____

Do you have any food intolerances or allergies?_____

Are there foods you crave? _____

Additional comments:_____

_____