ARIZONA NATURAL FAMILY MEDICINE – MARIO HOWELL M.Ed., N.D.

NEW PATIENT INTAKE

Patient Name: ______________________________ Date: ____________

Date of Birth: ________________ Age: ______

Street Address: ____

City: ________________ State: ______ Zip: ________ Email Address: ________________

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Highest Level of Education: ______________________________

Occupation: ______________________________ Employer: ______________________________

Hours/Week: ________ Martial Status: ☐ Single ☐ Married ☐ Separated ☐ Divorded ☐Widow(er)

Social Security Number: ________________________

Emergency Contact: ________________ Relation:____________ Phone Number: ______________

Regular Physician: ______________________________

How did you hear of Arizona Natural Family Medicine? ______________________________

____

____

____

List in Order of Importance what your concerns are:

1.
2.
3.
4.
5.

Last time you had blood work done: ____________ Which doctor? ______________________________

Family History

	Father		Mother		Grandparents	
Age (if living)	______		______		______	
Age (died)	______		______		______	
High Blood Pressure	Yes	No	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No	Yes	No
Asthma/Allergies	Yes	No	Yes	No	Yes	No
Auto-Immune Disease	Yes	No	Yes	No	Yes	No
Diabetes Mellitus	Yes	No	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No	Yes	No

List All Surgeries and Hospitalizations – including date occurred:

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

Please List All Sensitivities/Allergies/Reactions:

Drugs: ____

Foods: ____

Environment: ______________________________________

List Yes, No, or Past regarding use of the following:

Antacids: Yes No Past
Smoking: Yes No Past - Packs/day: _____
Analgesics: Yes No Past
Coffee: Yes No Past - Cups/day: _____
Soda Pop: Yes No Past - Ounces/day: _____
Alcohol: Yes No Past - How Often: _____ How Much: _____
Steroids: Yes No Past
Laxatives: Yes No Past

Alcohol Addiction: Yes No Past
Alcohol Treatment: Yes No Past
Recreational Drugs: Yes No Past
Drug Addiction: Yes No Past
Drug Treatment: Yes No Past

List All Prescription Medicines and Nutrient Supplement/Herbs Currently Being Taken:

Drug	**Dosage**	**Frequency/How Often**

Supplements	**Dosage**	**Frequency/How Often**

Review of Systems
Present Weight: _______ Weight One Year Ago: _______ Height: _______ Ideal Weight: ______

Overall Energy Level
0 (worst) to 10 (best) – Circle the level that best describes your energy level now.

0 1 2 3 4 5 6 7 8 9 10

If you have fatigue, when is it at its worst? Morning Afternoon Evening

If you have fatigue, can you do what you need to during the day? Yes No

<u>REGARDING NEXT SECTION</u>: Please circle Y if you have the problem **NOW**, **N** if you've **NEVER** had the problem, and **P** if you had the problem in the **PAST**.

Skin

Rash:	Yes	No	Past	Color Change:	Yes	No	Past
Hives:	Yes	No	Past	Lump:	Yes	No	Past
Psoriasis/Eczema:	Yes	No	Past	Itchy:	Yes	No	Past
Skin:	Yes	No	Past	Perspiration:	Yes	No	Past
Cancer:	Yes	No	Past				

Head

Headache:	Yes	No	Past	Migraine:	Yes	No	Past
Dandruff:	Yes	No	Past	Head Injury:	Yes	No	Past
Oil/Dry Hair:	Yes	No	Past	Hair Loss:	Yes	No	Past

Eyes

Dry/Watery:	Yes	No	Past	Blurry Vision:	Yes	No	Past
Double Vision:	Yes	No	Past	Cataracts:	Yes	No	Past
Glaucoma:	Yes	No	Past	Dark Under Eyelid:	Yes	No	Past
Strain:	Yes	No	Past	Discharge:	Yes	No	Past
Itchy:	Yes	No	Past				

Nose

Frequent Colds:	Yes	No	Past	Nose Bleeds:	Yes	No	Past
Congestion:	Yes	No	Past	Post Nasal Drip:	Yes	No	Past
Polyps:	Yes	No	Past	Seasonal Allergies:	Yes	No	Past

Mouth/Throat

Canker Sores:	Yes	No	Past	Cold Sores:	Yes	No	Past
Sore Throat:	Yes	No	Past	Gum Disease:	Yes	No	Past
Dentures:	Yes	No	Past	Hoarseness:	Yes	No	Past
Loss of Taste:	Yes	No	Past				

Neck

Stiffness:	Yes	No	Past	Swollen Glands:	Yes	No	Past
Full Movement:	Yes	No	Past	Tension:	Yes	No	Past

Respiratory

Cough:	Yes	No	Past	Wheezing:	Yes	No	Past
Shortness of Breath w/Exertion:	Yes	No	Past	Bronchitis:	Yes	No	Past
Pneumonia:	Yes	No	Past	Painful Breathing:	Yes	No	Past
Asthma:	Yes	No	Past				

Cardiovascular

High Blood Pressure:	Yes	No	Past	Murmurs:	Yes	No	Past
Low Blood Pressure:	Yes	No	Past	Palpitations:	Yes	No	Past
Arrhythmias:	Yes	No	Past	Chest Pain:	Yes	No	Past
Swelling:	Yes	No	Past				

Gastrointestinal

Heartburn:	Yes	No	Past	Recent Change in BM:	Yes	No	Past
Indigestion:	Yes	No	Past	Diarrhea or Constipation:	Yes	No	Past
Bloating:	Yes	No	Past	Hemorrhoids:	Yes	No	Past
Nausea:	Yes	No	Past	Gall Bladder Disease:	Yes	No	Past
Vomiting:	Yes	No	Past	Liver Disease:	Yes	No	Past
Change in Appetite:	Yes	No	Past	Ulcer:	Yes	No	Past
Pancreatitis:	Yes	No	Past	Bowel Movement Frequency: _______			

Urinary Tract

Incontinence:	Yes	No	Past	Pain with Urination:	Yes	No	Past
Frequent Infections:	Yes	No	Past	Kidney Stones:	Yes	No	Past
Urgency:	Yes	No	Past	Discharge/Blood:	Yes	No	Past

Male Genitalia (Male Only)

Testicular Pain/Swelling:	Yes	No	Past	Sexually Active:	Yes	No	Past
Hernia:	Yes	No	Past	Sexually Transmitted Disease:	Yes	No	Past
Discharge:	Yes	No	Past	Prostate Disease/Symptoms:	Yes	No	Past
Impotency:	Yes	No	Past	Sexual Orientation:	Yes	No	Past

Female Genitalia (Female Only)

Age Periods Began: ________
How Long Periods Last: ________
Date of Last Period: ________

Periods

Heavy Bleeding:	Yes	No	Past
Cramping:	Yes	No	Past
Pain:	Yes	No	Past
PMS:	Yes	No	Past
Food Cravings:	Yes	No	Past

Last Pap Smear: ________
Diagnosis: ________________
Any Abnormal Paps: Yes No Past
When Was Abnormal: ________
Any Birth Control (please list types and ages when used):
____
____
____

How Often Periods Occur: ____
Menopausal Since What Age: ____
Times Pregnant: ____
How Many Births: ____
Miscarriages: ____
Abortions: ____

Sexually Active:	Yes	No	Past
Healthy Libido:	Yes	No	Past
Pain with Intercourse:	Yes	No	Past
Dry Vagina:	Yes	No	Past

Vaginitis:	Yes	No	Past
Mammography:	Yes	No	Past
Dexa Scan:	Yes	No	Past

Dexa Scan Results:______________________________
____

Use of Hormones: Yes No Past

Musculoskeletal

Weakness:	Yes No Past	Arthritis:	Yes No Past
Stiffness:	Yes No Past	Leg Cramps:	Yes No Past
Tremors:	Yes No Past	Pain:	Yes No Past

Nervous

Paralysis:	Yes No Past	Sciatica:	Yes No Past
Tingling/Numbness:	Yes No Past	Carpal Tunnel Syndrome:	Yes No Past
Seizures:	Yes No Past	Fainting:	Yes No Past

Mental/Emotional

Depression:	Yes No Past	Anger/Irritability:	Yes No Past
Suicidal:	Yes No Past	High Stress:	Yes No Past
Anxiety:	Yes No Past	Fear/Panic:	Yes No Past

Exercise

How Often: ____

What Type(s): ____

For How Long: ____

Sleep

How Long Per Night: ____________________________________

If you wake up frequently, what is the reason: ____

Nightmares:	Yes No Past	Sleep Walk:	Yes No Past
Wake Refreshed:	Yes No Past	Grind Teeth:	Yes No Past
Must Nap During Day:	Yes No Past	Snore:	Yes No Past

Food

Nightmares: Yes No Past

Foods Crave: ____

Foods Disliked: ____

Foods That Don't Sit Well: ____