Good Integrative Healthcare LLC

New Patient Medical History Form

Name: First_____ Last _____ Date of Birth: _____

Address Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

E-Mail Address: _____

What is the primary reason for your office visit?

_____

When did these symptoms start?

_____

What are your goals for treatment? _____

Is there any health-related issue that could be impacting your symptoms? If yes, please explain:

_____

Primary Care Provider: _____ Phone: _____

Occupation: _____ How did you hear about us? _____

Current Symptoms / Conditions: (Please check all that apply)

GEN
- ○ Fatigue
- ○ Fever
- ○ Chills
- ○ Weight gain/loss

ENT
- ○ Headaches
- ○ Dizziness/fainting
- ○ Vision changes
- ○ Nasal congestion
- ○ Sore throat
- ○ Difficulty swallowing

- ○ Nausea/Vomiting
- ○ Abdominal pain
- ○ Black/bloody stools

RESP
- ○ Cough
- ○ Shortness of breath

HEART
- ○ Chest pain
- ○ Heart palpitations
- ○ Irregular Heartbeat

GYN
- ○ Pelvic Pain
- ○ Vaginal discharge

- ○ Walking to urinate
- ○ Incontinence

SKIN
- ○ Nail changes
- ○ Acne
- ○ Skin dryness
- ○ Rashes
- ○ Bruises easily

MS
- ○ Muscle aches
- ○ Joint Pain
- ○ Swelling in extremities

	○ Swollen Glands		○ Irregular menstruation	**MOOD**	○ Anxiety
GI	○ Constipation	**GU**	○ Bladder infections		○ Depression
	○ Diarrhea		○ Blood in urine		○ Irritability
	○ Bloating/gas		○ Urinary urgency	**NEURO**	○ Numbness/tingling
	○ Acid Reflux		○ Urinary Frequency		○ Weakness

Personal Past Medical History: (Please check all that apply and include date diagnosed)

○ Kidney Disease	○ Breast problems	○ Arthritis
○ High blood pressure	○ High cholesterol	○ Incontinence
○ Stomach problems	○ Thyroid disorders	○ Heartburn
○ Autoimmune disease	○ Cancer or Tumors	○ Fibroids
○ Depression	○ Migraines	○ Anxiety
○ Hormone problems	○ Tuberculosis	○ Stress
○ Respiratory problems	○ Blood disorder	○ Other

Family History:

Please list which family member(s) for each types of diseases:

Thyroid disease _____

Heart disease/High blood pressure_____

Stroke/High cholesterol _____

Autoimmune conditions _____

Kidney disease _____

Osteoporosis _____

Cancer _____

Diabetes _____

Blood/clotting disorder _____

Other _____

Surgical History: (Please list all surgeries that you have had since birth and indicate the year it was performed).

_____
_____
_____
_____
_____

Hospitalizations (include the year):

_____
_____
_____
_____

Injuries (include the year):

_____
_____
_____

Allergies to medications / foods/ other:

_____
_____
_____

Prescription Medications:

_____
_____
_____

Supplements/Vitamins/OTC:

_____
_____
_____

Health Maintenance Screening tests (List most recent date):

Physical Exam	Date:	Abnormal?	◯ Yes	◯ No
Colonoscopy	Date:	Abnormal?	◯ Yes	◯ No
Mammogram (women)	Date:	Abnormal?	◯ Yes	◯ No

Pap Smear (women)	Date:	Abnormal?	◯ Yes	◯ No
Bone Density Scan	Date:	Abnormal?	◯ Yes	◯ No
Rectal Exam (men)	Date:	Abnormal?	◯ Yes	◯ No

Social History

What is your marital status?

Do you drink alcohol? ◯ Yes ◯ No If yes, how often? _____

Do you drink caffeinated drinks? ◯ Yes ◯ No If yes, how often? _____

Do you smoke cigarettes? ◯ Yes ◯ No ◯ Never

If yes, how many packs/day? ____ How many years?_____ If no, quit date_____

Cannabis use? ◯ Yes ◯ No If yes, what form? _____

Sleep

How many hours of sleep do you get each night? _____

Do you have trouble falling asleep? ◯ Yes ◯ No Staying asleep? ◯ Yes ◯ No

Do you wake often? ◯ Yes ◯ No Do you wake refreshed? ◯ Yes ◯ No

Do you snore? ◯ Yes ◯ No Do you move a lot/restless during the night? ◯ Yes ◯ No

Do you take any sleep "aids"? ◯ Yes ◯ No

Type: ☐ Supplements ☐ OTC medications ☐ Ambien ☐ Trazadone ☐ Other

What is your nightly routine prior to going to sleep?

_____

Have you ever had an abnormal sleep study? ◯ Yes ◯ No

Do you use a CPAP machine or mouth guard? ◯ Yes ◯ No

Do you fall asleep with the TV on? ◯ Yes ◯ No

Movement / Exercise:

Do you exercise? ◯ Yes ◯ No If yes, what is the frequency/duration per week? _____

If yes, what activities? _____

Physicality of your job: ○ Sedentary ○ Mild/Moderately active ○ Manual/Strenuous ○ Varies

How many hours a day do you sit? (include both work and home activities) _____

Technology/Screen Time: How many hours a day do you:

Type/use a computer? Watch TV? Play video games? Social media? Text?

Do you bring a computer, tablet or phone to bed? ○ Yes ○ No

Thyroid Symptoms: (Mark all symptoms you are currently or have recently experienced)

- ○ Thinning hair/hair loss
- ○ Weight gain
- ○ Fatigue
- ○ Dry skin/hair
- ○ Puffy hands/face/feet
- ○ Cold hands/feet
- ○ Constipation
- ○ Muscle/joint aches
- ○ Low mood
- ○ Heart Palpitations
- ○ Feeling shaky
- ○ Racing heart
- ○ Wake up tired
- ○ Retain water in hands/feet
- ○ Foggy thinking, hard to focus
- ○ Headaches

Adrenal/Fatigue Symptoms: (Mark all symptoms you are currently or have recently experienced)

- ○ Heart Palpitations
- ○ Feeling Shaky
- ○ Low blood pressure
- ○ Low blood sugar
- ○ Feeling "wired but tired"
- ○ Significant recent weight gain/loss
- ○ Need caffeine to "get through the day"
- ○ Can't do anything once home from work (head straight to the couch)
- ○ Recent history of significant work/personal stress or loss
- ○ Tired all day, then get energy at night
- ○ Anxious or panicky
- ○ Increases fatigue after exercising
- ○ Mind racing during the night
- ○ Insomnia or trouble staying asleep

Weight

How many pounds have you lost or gained in the:

Past 6 months _____ Past 12 months _____ Past 3 years _____

What was your weight/BMI as an adolescent?

Do you have a family history of obesity? ○ Yes ○ No

List all types of diets you have tried in the past to lose weight:

_____

_____

_____

_____

Nutrition/Digestion (Mark all symptoms you are currently or have recently experienced)

- ○ Constipation
- ○ Diarrhea
- ○ Abdominal boating after meals or at end of day
- ○ Acid reflux
- ○ Food allergies
- ○ Foul smelling flatulence
- ○ Abdominal pain
- ○ Frequent belching

Do you struggle with: Sugar cravings? ○ Yes ○ No Salt cravings? ○ Yes ○ No

Do you crave sugars/dessert after dinner? ○ Yes ○ No

Do you ever wake up feeling nauseated? ○ Yes ○ No

Is it difficult for you to eat breakfast? ○ Yes ○ No

Do you ever get sweaty or dizzy if you don't eat regularly? ○ Yes ○ No

Do you have a history of frequent antibiotic use? ○ Yes ○ No

Have you travelled out of the country in the past 10 years? ○ Yes ○ No

Are you on any dietary restrictions? ○ Gluten-free ○ Vegetarian ○ Vegan ○ Other_____

eSignature

Please read the following statement carefully, then acknowledge that you have read and approved it by providing the information requested at the bottom of this page.

I have read through, understand and completed to the best of my ability Good Integrative Healthcare's Medical History form.

DO NOT E-SIGN UNTIL YOU HAVE READ THE ABOVE STATEMENT

Please enter your name (Last name, First name): _____

Please enter your date of birth (00/00/0000): _____

Please enter today's date (00/00/0000): _____