MIDDLEWAY MEDICINE

New patient intake

Name: DOB: date:

Primary care provider:

What are your two most important health concerns?

1._____ 2._____

Please circle any of the symptoms listed below that you are currently experiencing and underline any symptoms you have experienced in the past.

General Symptoms

headaches
dizziness
tired/low energy
worry/anxiety/nervousness/irritable
sleeplessness/sleep too much
frequent colds
depression
sweating irregularities
loss/gain weight
other:

Skin and hair

skin rashes
dryness, where?
acne/pimples
hives
oily skin
numbness
hair loss
skin ulcers/sores
bruise easily
cold sores/herpes
flush easily
athletes foot
other:

Eyes

blurred vision
dryness/burning
excessive watering
near/farsightedness
bloodshot, puffy
sensitivity to light
floaters
other:

Ears

earaches
ringing
loss of hearing
lots of wax
ear discharges
other:

Nose and Throat

sinusitis/nasal congestion
dry mouth/nose
dry/chapped lips
sore throat
sore tongue
lack of smell/taste
bleeding gums
hoarseness
nosebleeds
clear throat often
postnasal drip
other:

Cardiovascular

chest pain
heart beats fast or irregular
high/low blood pressure
swollen feet, ankles or legs
cold hands or feet
varicose veins
high cholesterol
other:

Musculo-skeletal

muscle pain or tenderness
if so, where?

swollen, painful, stiff joints
bone pain
tremors, twitches
feet, ankle, calf pain
loss of strength
muscle wasting
restless legs
other:

Respiratory

difficulty breathing
cough frequently
tightness in chest
spitting up mucous or blood
shortness of breath
other:

Gastrointestinal

low appetite
constant hunger
bad breath
heartburn/acid reflux
heaviness after eating
gas/belching
bloating
stomach, abdomen tenderness/cramping
symptoms relieved by eating or worse with eating
headache, dizziness, irritable with skipped meals
diarrhea or lose stools
constipation
light colored or greasy stool
dark stools
blood in stool
feeling of incomplete evacuation
undigested food in stool
foul odor of stool or gas
hemorrhoids
history of parasites
other:

Urinary

difficulty urinating
frequent urination
incomplete urination
bladder/kidney infection
kidney stones
other:

Female

irregular menstruation/peri-menopause
pain prior to or with periods
depressed, tense, irritable with periods
painful or swollen breasts
discharge from breasts
lumps in breast
symptoms in a monthly pattern
diminished or excessive sexual desire
difficulty having orgasm
inability to conceive
vaginal discharge
pain, discomfort, itching in genital area
hot flashes
history of fibroids or ovarian cysts
reproductive surgeries
menopause

date of last period:_____ # of days_____ length of cycle_____
date of last PAP smear: _____ Was it normal? _____
type of birth control:
pregnancies:_____ # of children:_____
ages of children:_____ type of delivery:_____

Male

prostate problems other:
difficult or unusual urination
discomfort or pain in genital area
diminished or excessive sexual desire
difficulty maintaining an erection

Spiritual Health

What do you do to connect with "SPIRIT"?

Are you satisfied with your spiritual health?

Habits

cigarettes/tobacco _____ packs per day
coffee or black tea _____ cups per day
sodas per day _____
8oz glasses of water per day _____
alcohol _____ drinks per week
marijuana _____ times per week
other drug use:
exercise?_____times per week_____how long_____what type_____

_____

Medications & Supplements

Are you currently taking any prescription medication? Please list:

Are you currently taking any vitamins/supplements? Please list:

Allergies

Please list any known allergies:

Surgeries/Hospitalizations

Have you had any of the following removed? Date?

tonsils _____ cysts/tumors _____

appendix _____ uterus/ovaries _____

gallbladder _____ other: _____

Have you ever been hospitalized or had a serious accident or illness?
Please list what, when and where.

Miscellaneous

Have you traveled outside of the USA within the past two years? Where?

Have you ever been diagnosed with:

AIDS Hepatitis

HIV TB

Exposed to AIDS

If yes, please give diagnosis/treatment dates:

Have you ever been exposed to significant doses of:

chemicals radiation

toxins other:

Family History

cancer	tuberculosis
heart problems	allergies
respiratory problems	psychological problems
urinary tract problems	birth defects
diabetes	thyroid problems
high blood pressure	asthma
migraines	other:

Any additional information that you feel we should know about: