Mederi Health
SPECIALISTS IN HEALTH & WELLNESS

New Patient Intake

Thank you for taking the time to fill out this paperwork. This is very valuable information. Please understand that we take the necessary time for each and every one of our patients to be properly diagnosed and treated.

Today's Date_____

Name_____ **Age**_____ **Birthday**____/____ /_____

Sex: M F **Email**_____

Address_____

City_____**State**_____**Zip**_____

Primary Phone_____ **Other Phone** _____

May we leave a voice mail message for you? Y / N

May we contact you via email with information about our practice and/or general health information? Y / N

Employer_____**Occupation**_____

Marital Status: S M W D **Spouses Name** _____

How did you hear about Mederi Health? Whom may we thank for the referral?

_____

In order of importance, please list the problems/symptoms prompting your request for a consultation with Mederi?

1.

2.

3.

4.

5.

6.

Would you consider these problems (circle one)

- **MINIMAL** -Annoying but causing NO limitations
- **SLIGHT** -Tolerable but causing a little limitation
- **MODERATE** (Sometimes tolerable causing limitations
- **EXTREME** -Causing near constant (>80% of the time) limitations

You know yourself and health better than anyone, in your opinion, what do you think the problem is?

_____

How long has it been an issue?

_____

What kind of treatments have you received?

Prescriptions/Drug Therapy:

_____ When (approx) _____

Nutritional Therapy:

_____ _____When (approx) _____

Alternative or Holistic Therapy:

_____ _____When (approx) _____

Surgery:

Type_____ When (approx)_____ _____

Other Therapies/Diets/Programs you have tried:

_____

Did any of these treatments make symptoms better or worse? If so which one (s) and how?

_____

If you cannot find a solution to this problem what do you think will happen to you?

_____

List ANY hospitalizations that you have had and the corresponding dates:

_____

_____

Please indicate anyone in your immediate family that has a severe disease such as cancer, diabetes, stroke, liver or heart disease:

_____

Any known allergies to medications, foods or supplements:

_____

Have you had any of the following in the last 12 months or currently?
(Mark C for current, X for in the last 12 mos.)

GENERAL

Chills_____ Body aches____ Dizziness____ Fainting____ Fatigue____ Fever____ Headache____
Loss of sleep____ Allergy____ (List Above) Loss of weight____ Nervousness____ Wheezing____
Bronchitis____ Numbness in BOTH hands and feet____

CARDIOVASCULAR

High blood pressure____ Low blood pressure____ Pain over heart____ Poor circulation____ Rapid heartbeat____ Previous heart problem____(describe_____) Slow heartbeat____
Stroke____ TIA____ Swollen ankles____ Varicose veins____ Aortic aneurysm___ Bruise easily____

DISEASES/CONDITIONS

Appendicitis____ Anemia____ Arthritis____ Alcoholism____ Abdominal surgery____ Bleeding disorder____
Blood clot(s)____ Breathing difficulty____ Cancer____ High cholesterol____ Gastrointestinal problems____
Diabetes____ Depression____ Epilepsy____ Eczema____ Eating disorder____ Glaucoma____ HIV +____
Heart disease____ Hernia____ Headaches/migraines____Hyperthyroidism_____Hypothyroidism_____
Influenza____ _ Kidney disease____ Liver disease____ Low back pain____ Mental Illness____ Measles____
Mumps____ Pleurisy____ Pneumonia____ Polio____ Prostate problems____ Rectal surgery____

Any diseases not listed above:_____

EARS/EYES/NOSE/THROAT

Asthma____ Crossed Eyes____ Double Vision____ Blurred Vision____ Difficulty swallowing____ Deafness____
Hearing loss____ Ear pain____ Thyroid problem____ Nose bleeds____ Sinus problems____ Sore throats____

GASTRO-INTESTINAL

Gas____ Constipation____ Diarrhea____ Gallbladder issues____ Hemorrhoids____ Liver disease____ Nausea____ Stomach pain____ Poor appetite____ Poor digestion____ Vomiting____ Vomiting blood____ Rectal bleeding____ Bloating____ Dark, tar colored stools_____Heartburn_____

GENITRO-URINARY

Blood in urine_____ Frequent urination____ Inability to control urine____ Kidney/Bladder infection_____ Painful urination____ Prostate issue_____

FOR MEN ONLY

Lump in testicles____ Penis discharge____

Any Previous Hormone Replacement Therapy:_____

FOR WOMEN ONLY

Menstrual cramps____ Excessive menstrual flow____ Hot flashes____Night Sweats_____ Irregular cycle____ Painful Periods____ Abnormal pap smear____ Hysterectomy (Partial/Full)_____Ablation_____

Any Previous Hormone Replacement Therapy:_____

Number of children_____

MUSCLE/JOINT/BONE

Back pain____ Foot pain____ Pain between shoulders____ Painful tailbone____ Stiff neck____ Spinal curvature____ Swollen/painful joints_____

NEUROLOGIC

Seizures____ Dizziness____ Hand trembling____ Weakness____ Difficulty with speech____ Loss of memory____ Loss of coordination____

RESPIRATORY

Chest pain____ Chronic cough____ Difficulty breathing____ Coughing/Spitting blood____

Additional Information for practitioner: