Medication Form

Name:_____ Date Completed:_____
Address:_____
Phone Number:_____ Birth Date:_____
Emergency Contact/ Phone:_____
E-Mail_____
(We give notice of any important changes and health information through e-mail. We will not send any notification by post mail.) Please tic the box is you do not wish to receive these updates by email. Δ
Allergies and Drugs to Avoid/Adverse Reactions:

_____
_____

Please list any other special dietary information, or foods you can or will not eat. (ex: vegan, vegetarian, etc.)

_____
_____
_____

Current Medications:

List all medications you are taking, include over-the-counter (e.g., supplements, prescriptions, aspirin, antacids).

Medication:_____ Dosage:_____
ReasonforTaking:_____ Directions:_____
DateStarted:_____ Date Discontinued:__

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Medication:_____ Dosage:_____
ReasonforTaking:_____ Directions:_____
Date Started:_____ Date Discontinued: _____

Immunization Record:
(Include dates administered)
Δ Tetanus_____ Δ Pneumonia Vaccine_____ Δ Flu Vaccine_____
Δ Hepatitis Vaccine_____ Δ Other_____

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Please give a short summary of what you would like to achieve regarding your health and your expectation of the ISHSKO WELLNESS CENTRE,

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ADULT INTAKE FORM

Patient Name:_____ **DOB:**_____ **Age:**_____

List in Order of importance what your problems are:

1) _____

2) _____

3) _____

4) _____

5) _____

Last time you had blood work done and with what physician: _____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living						
Age when died						
Reason for death						
Cancer type						
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1)_____ 4) _____

2)_____ 5) _____

3)_____ 6) _____

Please Note When & Why You Have Had Each of the Following:

X-Rays:_____ MRI/Cat Scans: _____

Ultrasounds:_____ Accidents:_____

TB Test:_____ HCV: _____

HIV:_____ Last Dental Visit: _____

Last Eye Exam: _____

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

Measles: D I N **Chicken Pox**: D I N **Mumps**: D I N **Rubella**: D I N

Tetanus: D I N **Whooping Cough**: D I N **Hemophilus (Hib)**: D I N **Hepatits B**: D I N

German Measles: D I N **Any vaccination reactions:** _____

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Patient Name: _____ DOB: _____

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Antacids: Y N P **Steroids**: Y N P **Smoking**: Y N P **Packs per day & number of years**: _____

Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day if Yes/Past**: _____

Soda Pop: Y N P **Ounces per day if Yes/Past**: _____

Alcohol: Y N P **How often & how much if Yes/Past**: _____

Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P

Recreational Drugs: Y N P **Any Drug Addictions**: Y N P

Any Drug Treatment: Y N P

List all known allergies and sensitivities to medication, environmental substances and foods:

_____

_____

_____

Review of Systems:

Present Weight: _____ **Weight one year ago**: _____ **Height**: _____

Ideal Weight: _____

REGARDING THE NEXT LONG SECTION: Please circle (**Y**) if you have the problem **NOW**, (**N**) if you've **NEVER** had the problem, (**P**) if you had the problem in the **PAST**.

Good Energy: Y N P

Fatigue: Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst? _____

If you have fatigue, can you do what you need to during the day? Y N

SKIN				
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer:	Y N P		**Perspiration:**	Y N P
HEAD				
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P
NOSE				
Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Post Nasal Drip:**	Y N P
Polyps:	Y N P		**Seasonal Allergies:**	Y N P

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EYES				
Dry/Watery:	Y N P		**Blurry Vision:**	Y N P
Double Vision	Y N P		**Cataracts/Glaucoma:**	Y N P
Glasses:	Y N P		**Styes:**	Y N P
Strain:	Y N P		**Discharge:**	Y N P
Itchy:	Y N P		**Dark under Eyelid:**	Y N P
MOUTH/THROAT				
Canker sores:	Y N P		**Cold sores:**	Y N P
Sore Throat:	Y N P		**Gum disease:**	Y N P
Dentures:	Y N P		**Cavities:**	Y N P
Loss of taste:	Y N P		**Hoarseness:**	Y N P
NECK				
Stiffness:	Y N P		**Swollen Glands:**	Y N P
Full movement:	Y N P		**Tension:**	Y N P
RESPIRATORY				
Cough:	Y N P		**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P		**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P		**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P		**Asthma:**	Y N P
Wheezing:	Y N P		**Painful breathing:**	Y N P
CARDIOVASCULAR				
High Blood Pressure:	Y N P		**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P		**Murmurs:**	Y N P
Arrhythmias:	Y N P		**Palpitations:**	Y N P
Edema:	Y N P		**Chest Pain:**	Y N P
URINARY TRACT				
Incontinence:	Y N P		**Pain w/ Urination**	Y N P
Frequent Infections:	Y N P		**Kidney Stones**	Y N P
Urgency:	Y N P		**Discharge/Blood:**	Y N P
GASTROINTESTINAL				
Heartburn:	Y N P		**Bowel Movement Freq:**	
Indigestion:	Y N P		**Recent BM Change:**	Y N P
Bloating:	Y N P		**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P		**Hemorrhoids:**	Y N P
Vomiting:	Y N P		**Gall Bladder Disease**	Y N P
Change in Appetite:	Y N P		**Liver Disease:**	Y N P
Pancreatitis:	Y N P		**Ulcer**	Y N P

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MALE GENITALIA				
Testicular pain/swelling:	Y N P		**Sexually Active:**	Y N P
Hernia:	Y N P		**S.T.D.:**	Y N P
Discharge:	Y N P		**Prostate Disease/Symptoms:**	Y N P
Impotency:	Y N P		**Sexual Orientation:**	Hetero Homo Bi

FEMALE GENITALIA				
Age Period Began:			**How Often Period Occurs:**	
How long period lasts:			**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P		**Menstrual Pain:**	Y N P
PMS:	Y N P		**Start date of last period:**	
Times Pregnant:			**How many births:**	
Miscarriages:			**Abortions:**	
Last Pap Smear:			**Diagnosis:**	
Any abnormal paps:	Y N P		**When was abnormal:**	
Menopausal since what age:			**Use of hormones:**	Y N P
Type of hormones used:			**Healthy libido:**	Y N P
Dry vagina:	Y N P		**Sexually Active:**	Y N P
Pain w/ Intercourse:	Y N P		**Vaginitis:**	Y N P
S.T.D.:	Y N P		**Mammography:**	Y N P
Dexa Scan:	Y N P		**If Yes, what were results:**	
Sexual Orientation:	Hetero Homo Bi			

Please list any birth control used and ages used: _____

MUSCULOSKELETAL				
Weakness:	Y N P		**Arthritis:**	Y N P
Stiffness:	Y N P		**Leg Cramps:**	Y N P
Tremors:	Y N P		**Pain:**	Y N P

NERVOUS				
Paralysis:	Y N P		**Sciatica:**	Y N P
Tingling/numbness:	Y N P		**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P		**Fainting:**	Y N P

Mental/Emotional				
Depression:	Y N P		**Anger/irritability:**	Y N P
Suicidal:	Y N P		**High-strung/tense:**	Y N P
Anxiety:	Y N P		**Fear/Panic**	Y N P
Eating disorder:	Y N P		**Psych Hospitalization:**	Y N P

Exercise

How often do you exercise?_____ **What type of exercise**? _____

For how long?_____ **Hobbies**: _____

Sleep

How long per night?_____ **If you wake up frequently, what is the reason**? _____

Nightmares: Y N P **Wake Refreshed**: Y N P **Must nap during the day**: Y N P

Sleep walk: Y N P **Grindteeth**: Y N P **Snore**: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

Social Life

Enjoy job: Y N P **Hours worked per week**:_____ **Excessive exposure to environmental toxins:** Y N P

Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: Y N P **If so, at what age and by whom**: _____

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: Little Moderately Very

Ethnic Background: _____

Typical Day's Diet

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks: _____

Allergies

List all known Allergies (food, drugs, environment): _____

Patient Signature: Date