Atlanta Integrative & Internal Medicine

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PERSONAL INFORMATION **TODAY'S DATE _____/_____/_____**

NAME: LAST_____ FIRST _____ MIDDLE INITIAL _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____

** Please circle the phone number you wish to be contacted with results.
May we leave a voice message on that phone with your results? YES NO

HOME PHONE (____) _____ - _____ **CELL** (_____) _____ - _____ WORK (_____) _____ - _____

DATE OF BIRTH _____/_____/_____ **SEX** □ F □ M **SOCIAL SECURITY #** _____ / _____ / _____

EMAIL ADDRESS _____ (*will NOT be shared*)

PRIMARY CARE DOCTOR _____ REFERRING PHYSICIAN _____

MARITAL STATUS: □ SINGLE □ DIVORCED □ LEGALLY SEPARATED □ PARTNER

□ MARRIED (SPOUSE NAME _____) □ WIDOWED □ UNKNOWN

EMPLOYER NAME _____ ADDRESS _____

EMPLOYMENT STATUS: □ FULL TIME □ NOT EMPLOYED □ RETIRED □ PART TIME
□ SELF EMPLOYED □ ACTIVE MILITARY

STUDENT STATUS: □ FULL TIME □ PART TIME

RESPONSIBLE PARTY: □ SELF □ GUARANTOR **R**ELATIONSHIP_____

NAME_____ ADDRESS _____

CITY_____ STATE _____ ZIP_____

DOB_____/_____/_____

EMERGENCY CONTACT:

NAME LAST_____ FIRST _____ RELATIONSHIP_____

ADDRESS_____ CITY _____ STATE _____ ZIP _____

THEIR HOME PHONE (_____) _____ - _____ THEIR WORK PHONE (_____) _____ - _____

AUTHORIZATION TO RELEASE INFORMATION TO:

NAME _____ RELATIONSHIP _____PHONE (_____) _____ - _____

PHARMACY:

NAME _____ LOCATION _____

PHONE (_____) _____ - _____ FAX (_____) _____ - _____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I authorize *Crabapple Integrative and Internal Medicine* and my insurance company to release any information required to process my claims.

Patient or Guardian Signature: _____Date

What brings you to see the clinic today?

_____
_____
_____

What are your most important health concerns (Top 3)?

1)

2)

3)

How did you hear about our clinic?

_____

Medical History

Please list all previous diagnoses of any medical conditions:

_____
_____
_____

Hospitalizations:

What hospitalizations or surgeries have you had? _____
_____
_____

Imaging:

What diagnostic imaging studies have you had? ☐ X-rays ☐ CT scan ☐ PET scan ☐ MRI
☐ Endoscopy ☐ Colonoscopy ☐ Sigmoidoscopy ☐ Bone density scan ☐ Mammogram
☐ EKG/ECG ☐ EEG

Were there any significant findings?

_____
_____
_____
_____

Allergies:

Are you aware of any **allergies** to food, drugs, or other environmental allergens (cats, mold, and dust)? If yes, please list and explain:

_____

Childhood Illnesses

Please circle whether you have/had any of the following conditions:

Diptheria	Mumps	Polio	Rubella
German measles	Rheumatic fever	Pertussis	Chronic Ear or Throat infections
Measles	Scarlet fever	Chicken Pox	
Tuberculosis	Other _____		

Past Immunizations

Please circle any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diptheria	Polio	Hepatitis A/ B
Measles/Mumps/Rubella (MMR)	Tetanus	HiB
Pertussis	Varicella (Chicken Pox)	Influenza; annually? Yes / No

Other(s) _____

Family History

Do you have a family history of any of the following (please circle)?

Anemia	Diabetes	Goiter	Kidney disease
Arthritis	Epilepsy	Hay fever/hives	Liver disease
Asthma	Gall bladder disease	Heart disease	Mental illness
Cancer	Glaucoma	Heart murmur	Stroke
Cataracts	Gluten Sensitivity	High blood pressure	Tuberculosis

Is your father still living? Yes; his age ____ No; age at time of death _____ Cause of death _____

Is your mother still living? Yes; her age ____ No: age at time of death _____ Cause of death _____

Review of Systems

Please circle. Y= Yes, present condition P=Problem of the past N=No, never had the condition.

Head

Headaches	Y P N	Migraine headaches	Y P N		
Head injury	Y P N	Jaw/TMJ problems	Y P N		

Ear

Ringing	Y P N	Dizziness	Y P N	Frequent wax build up	Y P N
Earaches	Y P N	Impaired hearing	Y P N	Itchy or moist ears	Y P N

Eyes

Blurred vision	Y P N	Cataracts	Y P N	Glasses/contacts	Y P N
Eye pain/strain	Y P N	Glaucoma	Y P N	Tearing/dryness	Y P N
Spots in eyes	Y P N	Color blind	Y P N	Double vision	Y P N

Nose/Sinuses

Stuffiness	Y P N	Loss of smell	Y P N	Sinus problems	Y P N
Hayfever	Y P N	Nose bleeds	Y P N	Frequent discharge	Y P N

Mouth/Throat

Hoarseness	Y P N	Gum problems	Y P N	Freq. sore throat	Y P N
Jaw clicks	Y P N	Dental cavities	Y P N	Sore lips/tongue	Y P N
Dry Mouth	Y P N				

Neck

Lumps	Y P N	Swollen glands	Y P N
Goiter	Y P N	Pain or stiffness	Y P N

Skin

Rashes	Y P N	Psoriasis	Y P N	Eczema, hives	Y P N
Lumps	Y P N	Acne, boils	Y P N	Color changes	Y P N
Itching	Y P N	Loss of hair	Y P N	Night sweats	Y P N

Respiratory

Asthma	Y P N	Wheezing	Y P N	Spitting up blood	Y P N
Cough	Y P N	Bronchitis	Y P N	Difficulty breathing	Y P N
Sputum	Y P N	Pneumonia	Y P N	Pain with breathing	Y P N
Pleurisy	Y P N	Emphysema	Y P N	Shortness of breath	Y P N
Tuberculosis	Y P N	Difficulty breathing while lying down at night	Y P N		

Cardiovascular

Angina	Y P N	Chest pain	Y P N	Blood clots	Y P N
Murmur	Y P N	Heart disease	Y P N	Rheumatic fever	Y P N
Fainting	Y P N	Ankle swelling	Y P N	Low/high blood pressr	Y P N
Anemia	Y P N	Cold hands/feet	Y P N	Thrombophlebitis	Y P N
Leg pain	Y P N	Easy bruising	Y P N	Varicose veins	Y P N

Gastrointestinal

Diarrhea	Y P N	Constipation	Y P N	Ulcers	Y P N
Black stool	Y P N	Coughing up blood	Y P N	Jaundice	Y P N
Hemorrhoids	Y P N	Gall bladder disease	Y P N	Heartburn	Y P N
Abdominal pain	Y P N	Blood in stool	Y P N	Liver disease	Y P N

How many bowel movements per day? _____
Are they generally: loose well-formed dry and hard pebble-like

Urinary

Incontinence	Y P N	Frequent infections	Y P N	Painful urination	Y P N
Kidney stones	Y P N	Frequency at night	Y P N	Change in color / odor	Y P N

Musculoskeletal

Joint pain	Y P N	Muscle spasms	Y P N	Stiffness	Y P N
Arthritis	Y P N	Muscle pain/soreness	Y P N	Broken bones	Y P N
Sciatica	Y P N	Muscle weakness	Y P N		

Neurological

Fainting	Y P N	Paralysis	Y P N	Numbness/tingling	Y P N
Seizures	Y P N	Loss of memory	Y P N	Muscle weakness	Y P N

Emotional

Mood swings	Y P N	Nervousness	Y P N	Tension/stressed	Y P N
Anxiety	Y P N	Depression	Y P N	Loss of loved one	Y P N

Endocrine

Hypothyroid	Y P N	Excessive thirst	Y P N	Cold intolerance	Y P N
Hyperthyroid	Y P N	Excessive hunger	Y P N	Heat intolerance	Y P N

Male Reproductive

Hernias	Y P N	Testicular masses	Y P N	Discharge or sores	Y P N
Prostate issues	Y P N	Sexual difficulty	Y P N	Testicular pain	Y P N
Premature Ejaculation	Y P N	Sexually transmitted disease/infections	Y P N	Blood in semen	Y P N

Female Reproductive

Age of first menses _____ Age of last menses (if menopausal) _____
Length of cycle _____ Duration of menses _____
Date of last gynecological annual exam _____

Painful menses	Y P N	Endometriosis	Y P N	Ovarian cysts	Y P N
Heavy flow	Y P N	Fertility issues	Y P N	Cervical dysplasia	Y P N

Breast tenderness	Y P N	Venereal disease	Y P N	Bleeding between cycles	Y P N
Sexually active	Y P N	Cycles regular	Y P N	Menopausal symptoms	Y P N
Sexual difficulty	Y P N	Abnormal pap	Y P N	PMS	Y P N
Breast lump(s)	Y P N	Nipple discharge	Y P N	Do self breast exams	Y P N
Birth control	Y P N	If yes, what type?_____			

Number of pregnancies _____ Number of live births _____
Number of miscarriages _____ Number of abortions _____

Environmental

Circle any of the following you routinely use at home: *Gas heat Oil heat Electric heat Wood stove Air conditioning Electric blanket T.V. Distilled/ Filtered/ Spring/ Well/ Deionized/ Tap water*

Is your home and work environment well ventilated?

_____

Is your home or work environment excessively damp or moist?

_____

Has there been any known mold growth, leaks, or large spills in your home or place of employment?

_____

_____

Please circle any of the following you feel most bothered by*:*

Sunshine Lack of sunshine Dampness Dryness Cold Heat Seashore Mountains New Moon Full Moon Dust/Mold Cat or Dog hair Car fumes Poor air/ ventilation Spring Summer Fall Winter Change in weather (specify) Wind Approach of a storm Fluorescent lighting Chemicals Other (specify)

_____

Do you get outdoors daily, even in the winter? _____

How do you feel about your work? Do you enjoy it, are you satisfied and fulfilled by it, does it provide you with the necessities of life, is it just a job you feel you must put in the hours in order to make a living?

_____

_____

Have you ever lived in or near an industrial area, waste management area, known environmentally contaminated area? _____

Have you ever worked with chemicals, pesticides, solvents, plastics, resins, metals, etc?

_____

Do any of your hobbies include the use of chemicals, pesticides, solvents, plastics, resins, metals, etc?

_____

Is there anything else you would like us know in order to serve you better?

_____

_____