Patient Name: ____________________________

REJUVENA
HEALTH & AESTHETICS

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New Patient Intake Form

Personal History

Name: ________________________________ Date of Birth:___/____/_____ Age:____ Date:____________

Address:____ Occupation: ___________________

How did you hear about us?____

Spouse or Partner Name: ____

Blood Type: Type O______ Type A______ Type B______ Type AB______ Negative______ Positive______

Allergies (including drugs, food, and environmental):

____

____

____

Main problems or reasons for this appointment: (rank in terms of importance to you)

1. ____
2. ____
3. ____
4. ____
5. ____

Current Medications	Dose	Times / Day

Current Vitamins / Herbs / Supplements	Dose	Times / Day

Patient Name: ______________________

Past Medical, Surgical, & Trauma History

List prior illness, injury, hospitalization, surgery, and/or trauma:

Event	Date

Personal and Family History

Check all that apply

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

Please list any complications with your own birth: ______________________________

____

____

Patient Name: ____________________________

Social History

Check all that apply:

<u>Marital Status</u>:
single_____
partnership_____
married_____
divorced_____
widowed_____

<u>Highest Education Completed</u>:
high school_____
college_____
graduate level_____
other: _________________

<u>Childhood Memories</u>:
mostly happy_____
mostly painful_____
normal_____
don't recall_____

<u>Do You Find Your Life:</u>
satisfactory_____
unsatisfactory_____
too demanding_____
boring_____

Major Stresses in Last 6 Months
money_____ job_____ marriage_____ home life_____ children_____ other_____: ______________________________
____

Pertinent Travel History (out of USA, epidemic areas, etc.): ____
____
____

Lifestyle / Self-Care Issues

Do you smoke cigarettes? YES__ NO__ If yes, how many? #_____Yrs. ____________Packs per day
Did you ever smoke? YES__ NO__ If yes, when did you quit?_____________________________
Do you drink alcohol? YES__ NO__ If yes, how much? Type____________ & ___________ Drinks per week?
Do you drink caffeinated beverages? YES__ NO__ If yes, which? _______________________________________
Do you use recreational drugs? YES__ NO__ If yes, which? _______________________________________
Are you sensitive to perfumes or chemicals? YES__ NO__
Do you manage stress well? YES__ NO__ NOT SURE__ NEED HELP__
Do you exercise? YES__ NO__ If no, why? _______________________________________
If yes, how much and how often? ______________________
Do you enjoy your job? YES__ NO__ If no, why? _______________________________________
How many hours per week do you work? ________
Do you allow time to unwind and relax? YES__ NO__ If no, why? _______________________________________
Do you sleep soundly? YES__ NO__ If no, why?_______________________________________
Is your diet healthy enough? YES__ NO__ NOT SURE__ NEED HELP__
Are you satisfied with your relationship? YES__ NO__ If no, why? _______________________________________
Are you satisfied with your social life? YES__ NO__ If no, why? _______________________________________
Are you satisfied with your spiritual life? YES__ NO__ If no, why? _______________________________________
How many ounces of water do you drink per day? __________________

Height: _____ft _____in
Present weight: _____lbs Weight 1 yr ago: _____lbs Ideal Weight: _____lbs Max Weight: _____lbs
Typical breakfast ____
Typical lunch ____
Typical dinner ____
Typical snacks ____

<u>Do You Use or Have</u>:
Eyeglasses____ Contact Lens____ Hearing Aid____ Brace (Neck, Back) ____
Pacemaker____ Dentures ____ IUD, Diaphragm____ Artificial Limbs____

Patient Name: ____________________________

Health Screening History

List the date of your most recent test or exam.

Mammogram ____________________ Rectal Exam ______________________ Scope Lower Bowel ______________
Pap Smear________________________ Test for Blood in Stool ______________ Scope Upper Bowel ______________
Self Breast Exam __________________ Prostate Exam ___________________ Cholesterol _____________________
Breast Exam by Doctor ______________ Self Exam Testicle _________________ Blood Sugar _____________________
Dexa (Bone Density) Scan____________ Testicle Exam by Doctor ____________ Hba1C___________________________
Other Blood Tests____

Immunizations

List dates for children and yes/no for adults

DTP = Diptheria __________________ Tetanus ______________________ Whooping Cough (Pertussis) ___________
MMR = Measles __________________ Mumps ______________________ Rubella ___________________________
German Measles _________________ Polio ________________________ Haemophilus influenzae ______________
Chicken Pox _____________________ Hepatitis _____________________ Pneumonia _________________________
Flu Shot_________________________
Please list any vaccine complications: ____
____

Procedures

Please list the date of any procedures:

Anatomy\Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	Pet Scan	EMG
Back							
Brain							
Chest							
Colon							
Extremities (Arm/ Leg)							
Gallbladder							
Kidney							
Neck							
Pelvis							
Stomach							
Other: ____________							

Menstrual Cycle and History (females)

Age of first period _______ Cycle: regular___ irregular___ Length of Menses_____ Length of Cycle_____
#Pads/Tampons per day _________ Color? _______ Clots? _______ 1st Day of Last Period ___________
Date of Last Pap Smear _________ Was it Regular? ______
Have you ever had an irregular Pap Smear? YES___ NO___ If yes, date/treatment? _________________________
____
Do you have any of the following PMS symptoms? breast tenderness___ bloating___ mood changes___
headaches___ cravings ___ other:____
Pain with menses: YES___ NO___ Severity/Treatment: ____

Sexual History

Currently sexually active: YES___ NO___ Sexual Difficulties: YES___ NO___

Patient Name: ____________________________

Male and Female	Yes/No	Date
HPV		
Herpes		
Chlamydia		
Gonorrhea		
Syphilis		
HIV/AIDS		
Trichomoniasis		
Leakage of urine		
Yeast Infections		
Infertility		
DES Exposure before birth		
Sores/Discharge		
Male Only		
Impotence		
Testicular Pain/Swelling		
Female Only		
Toxic Shock Syndrome		
Pelvic Inflammatory Disease (PID)		
Pain or Bleeding with Intercourse		
Abnormal/Irregular Vaginal Bleeding		
Vaginal Dryness		
Endometriosis		
Ovarian Cysts		
Uterine Fibroids		
Breast Disease		
Breast Surgery		
Cervical Cancer		
Uterine Cancer		
Ovarian Cancer		
Surgery on Ovaries		
Hysterectomy		
Colposcopy		
Cryosurgery		
Laser Surgery		

Past Pregancies

Child's Name					
Month/Day/Year					
Week of Delivery					
Length of Labor					
Birth Weight					
Sex M/F					
Type of Delivery Vaginal / C-Section					
Anesthesia					
Hospital or Homebirth					
Preterm Labor Y/N					
Comments / Complications					

Patient Name: ____________________________

Review of Systems

Age: Date:

For Physician's Use ________________

General

Weight change____ Fever/chills____ Weakness____
Fatigue____ Sweating/night sweats____

Skin

Rashes____ Itching____ Hair/nail change____
Acne____ Hives____ Eczema____
Scaling____

Head

Headache____ Head injury____ Hair Loss____
Dandruff ____ Oily/Dry Hair ____

Eyes

Vision/glasses____ Blurring____ Floaters ____
Cataracts____ Dryness____ Pain____
Tearing____ Discharge____ Glaucoma____

Ears

Ringing____ Discharge ____ Difficulty hearing____
Recurrent Ear Infections____ Ear aches____

Nose

Sinusitis____ Discharge____ Postnasal drip ____
Bleeding____ Obstruction____ Frequent colds____
Hayfever ____ Persistent running____ Nose bleeds____
Polyps____

Mouth/Throat

Gum bleeding____ Toothache____ Sore throat____
Sores____ Hoarseness____ Bad breath ____
Difficulty swallowing____

Neck

Goiter____ Lumps____ Swollen glands____
Trauma____

Pulmonary

Diff. Breathing ____ Wheezing____ Chest pain____
Coughing blood____ Chronic cough____ TB exposure ____
Shortness of breath____

Cardiovascular

Heart trouble____ Hypertension____ Sleep with ≥ 2 pillows ____
Chest pain____ Murmurs ____ Swelling of hands/ankles/feet____
Palpitation ____ Blue hands or feet____ Claudication (clotting) ____
Leg pain with walking____ Dizziness____ Ankle swelling____

Breasts

Masses____ Pain ____ Discharge____

Gastrointestinal

Loss of appetite____ Abdominal pain____ Heartburn ____
Hernia____ Rectal bleeding____ Gas, bloating ____
Constipation ____ Anal discomfort____ Loose Stool____
Hemorrhoids____ Nausea____ Vomiting____
Diarrhea____
How often do you have a bowel movement?____________________

Genitourinary

Painful urination____ Awaking in night to urinate____ Blood in urine____
Urgency____ Frequent urination____ Kidney stones ____
Incontinence/dribbling____

Sexual History

Please note any changes:

____
____
____
____

Patient Name: ____________________________

For Physician's Use

Male

Hernias____	Testicular pain____	Testicular masses____
Discharges____	Sores____	prostate disease____

Female

Menopause____	Spotting____	Nipple discharge____
Irregular menses____	Vaginal discharge____	Painful intercourse____
Hot flashes____	Vaginal dryness____	Decreased sex drive____
Vaginal itching____	Breast pain____	History of venereal disease____

Other: ______________________

Endocrine

Hormonal problems____	Tremors ____	Diabetes____
Hormone therapy____	Excessive urination____	Fatigue____
Heat/Cold intolerance____	Excessive thirst____	

Bones, joints & muscles

Injury____	Swelling____	Pain/Arthritis____
Stiffness____		

Mental Emotional

Anxiety ____	Depression____	Excessive anger____
Tension/Stress____	Mood swings____	

Tongue body:

Tongue coating:

pH:

Other Symptoms:

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