



INITIAL HISTORY/PRECONSULT FORM

TODAYS DATE: _____

Patient Name (on each page) _____ DOB: _____ AGE: _____

List, in order of importance, your goals for working with your physician, Dr. Aidun N.M.D:

- 1) _____ 2) _____
- 3) _____ 4) _____

Date of your recent: (please complete the information below to the best of your ability)

Mammogram _____ @ Imaging center: _____

Pap Smear _____ @ Office of Dr. _____

Bone Density _____ @ Imaging center/Office of _____

Blood Work _____ Ordered by: _____

Physical _____ by Dr. _____

Colonoscopy _____ @ imaging center/office of _____

Have you had a Hysterectomy? Y/N If yes, were your ovaries removed? _____

What was the reason for Hysterectomy? _____ Date of Hysterectomy _____

PRESENT MEDICAL HISTORY

Please list any medical conditions you are currently experiencing:

- 1. _____ 2. _____
- 3. _____ 4. _____

PAST MEDICAL HISTORY

Please list any medical conditions you did experience in the past:

- 1. _____ 2. _____
- 3. _____ 4. _____

Any allergy to food or drugs? Y N

If Yes, what is the allergen? _____ Reaction you experience: _____

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Family History
Y=Yes N=No

	Father	Mother	Siblings	Grandparents	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
Heart Attack and/ or Stroke: (please mark)	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N
Hypothyroidism	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

Did you have the following Disease (D), Get Immunized (I), or Neither (N):

Measles: D I N	Chicken Pox : D I N	Mumps: D I N
Tetanus: D I N	Whooping Cough: D I N	Hemophilus (Hib): D I N
Hepatitis B: D I N	German measles: D I N	Rubella: D I N

Any vaccination reactions: _____

List Yes (Y), No (N) or Past (P) regarding use of the following:

	<u>Y</u>	<u>N</u>	<u>P</u>	<u>Comment(including the amount consumed)</u>
Antacid				
Analgesics				
Soda Pop				
Alcohol				
Water				
Laxative				
Coffee				

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

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Review of Systems(Continue):

<u>NECK</u>			
Stiffness:	Y N P	Swollen Glands:	Y N P
Full movement:	Y N P	Tension:	Y N P

<u>RESPIRATORY</u>			
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

<u>CARDIOVASCULAR</u>			
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

<u>URINARY TRACT</u>			
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

<u>GASTROINTESTINAL</u>			
Indigestion:	Y N P	Recent Bowel 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
Heartburn	Y N P		Number of Bowel movements: _____ per day

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Review of Systems(Continue):

FEMALE GENITALIA

Age period began:		Pain with intercourse:	Y N P
How long period lasts?		STD:	Y N P
Heavy menstrual bleeding	Y N P	Date first day of your last menstrual cycle(important)	
How often period occurs?		Times pregnant	
Menstrual cramping	Y N P	Miscarriages	
PMS	Y N P	Abortions:	Y N P
Food Cravings	Y N P	Healthy libido	Y N P
Menopausal since what age?		Hot flashes	Y N P
Use of hormones	Y N P	Mood changes	Y N P
Type of hormones used		Memory/concentration problem	Y N P
:Sexually active	Y N P	Sleep issues	Y N P
Abnormal pap smear	Y N P	When?	Diagnosis

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

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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

Grind teeth: Y N P

Snore: Y N P

Social Life

Enjoy job: Y N P Hours worked per week: _____

What is your greatest health concern? _____

How does it limit you the most? _____

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

Typical Days Diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

End of the intake form

