Confidential Patient Information (please print)
Name: _____ Date of Birth: _____
Biological Gender: [ ]Female [ ] Male Gender Identification: _____
Address: _____ City:_____ State: _____
Zip:_____ Telephone: (_____)_____
Email address: _____
Emergency Contact: _____ Relationship: _____
Telephone: _____

How did you hear about Prema Health?:_____

Holistic and preventative healthcare is enhanced dramatically when the practitioner has a complete picture of the patient physically, mentally, emotionally, and spiritually. We ask for your cooperation in completing this questionnaire to the best of your ability. The more information you provide, the better we will be able to serve your health care needs.

Current Primary Care Information:
Are you establishing Prema Health as your primary care office? [ ] Yes [ ] No
If not, please list your primary care physician: _____
Are you being treated by any other practitioners?:
Practitioner and Clinic Name: _____

Health Concerns:
List in order of importance, your health concerns, and how long you have had these concerns or conditions

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

How would you rate your overall health?: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

What expectations do you have for your first visit?: _____
_____

What are your long term expectations in our work together?: _____
_____

What is your present level of commitment to address any underlying causes that are impacting your health? (Please rate 1 - 10, 10 being 100% committed): _____
What prevents your health from being a 10?:_____
_____
_____
What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?: _____
_____
_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe may negatively impact your health?: _____
_____
_____

Medications:

Please check any of the following that you take:

[ ] Antacids (Rolaids, Tums)
[ ] Antihistamines (Claritin, Benadryl
[ ] Diet pills
[ ] Oral Contraceptives
[ ] Thyroid Medication
[ ] Others: _____
[ ] Cortisone (cream or pills)
[ ] Cough or Cold medications
[ ] Laxatives
[ ] Sleeping pills
[ ] Pain Relievers (aspirin, Tylenol, Aleve, Motrin)

List all medications with dosages that you are currently taking (Prescription, supplements, herbs, homeopathy, vitamins, minerals, etc.)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

Allergies:

Are you allergic to any medications? [ ] Yes [ ] No
If yes, please list: _____
What is your reaction to these medications? _____
Do you currently or in the past have any other allergies to foods, drugs, or other allergens in your environment (e.g. cats, mold, dust, etc.)_____
_____

What hospitalizations or surgery have you had? Please give dates and reasons:
_____
_____

What diagnostic imaging studies have you had? (Please include approx. date)

[ ] Bone Density Scan (DXA) _____ [ ] Colonoscopy/Sigmoidoscopy _____
[ ] CTScan _____ [ ] Endoscopy _____
[ ] Electrocardiogram (ECG/EKG)_____ [ ] Electroencephalogram (EEG) _____
[ ] Echocardiogram _____ [ ] Laparoscopy _____
[ ] Mammogram _____ [ ] Ultrasound _____
[ ] X-Ray _____ [ ] MRI _____
[ ] Thermography _____ [ ] Others: _____

Are your vaccinations up to date?: [ ] Yes [ ] No
Are there any vaccinations you have declined?: [ ] Yes [ ] No
Do you get the flu shot?: [ ] Yes [ ] No

Have you had any of the following childhood illnesses?

[ ] Diptheria
[ ] Measles
[ ] Rheumatic Fever
[ ] Strep Throat
[ ] Others: _____
[ ] German Measles
[ ] Mumps
[ ] Scarlet Fever
[ ] Chicken Pox

Social History:

Occupation_____

[ ] Full Time [ ] Part Time [ ] Student [ ] Retired [ ] Disabled [ ] Unemployed

Relationship Status:

[ ] Single [ ] Married [ ] Long-term relationship [ ] Separated [ ] Divorced [ ] Widowed

Living Arrangements:

[ ] Alone [ ] Spouse [ ] Partner [ ] Parents [ ] Children [ ] Friends [ ] Other

Describe your support network: _____
_____
_____

Food & Diet (Please describe your typical food intake)

Breakfast	Lunch	Dinner	Snacks	Beverages
				Water _____/day Type of water? _____

Favorite foods: _____
_____

What % of your diet is packaged/pre-made/to go? _____%

How many times you eat out per week _____

Do you follow a certain type of diet? [ ] Yes [ ] No Please explain: _____
_____

Do you or have you ever had an eating disorder? [ ] Yes [ ] No Please explain: _____
_____

Health Habits	Yes	No	If yes, how long and/or how often per week?
Do you exercise?			
Do you apply sunscreen?			
Do you smoke tobacco? (Past or present)			
Do you drink alcohol?			
Do you use recreational drugs?			
Have you ever been treated for drug/ alcohol dependence?			
Do you drink coffee, soda, or black tea?			
Do you drink “diet” soda or eat “diet” foods? (gluten free, fat free, etc.)			
Are you familiar with “safe sex practices”?			
Do you follow any dietary modifications?			
Do you follow a spiritual practice?			
Do you have any hobbies/interests?			

General Review					
Do you...	**Yes**	**No**		**Continued...**	
Sleep well?				Current weight	
Wake feeling rested?				Weight one year ago	
Use a computer? Hours/week?				Max. adult weight, date?	
Enjoy your work?				Min. adult weight, date?	
Spend time outside?				Current adult height	
Take vacations?				Best energy level? (time of day)	
Watch television? Hours/week?				Lowest energy level? (time of day)	
Read? Hours/week?				Subjectively, do you feel your temperature runs warm or cool?	

Family Medical History
Please mark an **X** for any of the following that you or your family members have had:

Condition	Self	Father	Mother	Siblings	Grandparents	Children
ADD/ADHD						
Alcoholism						
Allergies						
Anemia/Blood Disorder						
Anxiety/Depression						
Arthritis						
Asthma						
Autoimmune Disease						
Blood Vessel Disorder						
Cancer (type)						
Diabetes						
Epilepsy/Seizure						
Gallbladder Disease						
Gastrointestinal Disorder						
Glaucoma/Cataracts						
Gynecological Disorder						
Headaches/Migraines						
Heart Disease/Attack						
High Blood Pressure						
High Cholesterol						
Hypoglycemia						
Infertility						
Kidney Disease						
Liver Disease						
Lung Disease / TB						
Menstrual Disorder						
Neurological Disorder						
Obesity						

Condition	Self	Father	Mother	Siblings	Grandparents	Children
Pain, Chronic						
Skeletal Disorder						
Skin Disorder						
Stroke						
Thyroid Disorder						
Ulcers						
Urinary Disorder						
Deceased family members? Age of death?						

Past Medical History: Review of Systems
(Please check the conditions that apply. C = Current and P = Past)

General
C P
[ ] [ ] Fatigue
[ ] [ ] Weight gain
[ ] [ ] Weight loss
[ ] [ ] Night sweats
[ ] [ ] Heat/Cold intolerant
[ ] [ ] High/Low blood sugar

Head/Neck
C P
[ ] [ ] Headaches
[ ] [ ] Head injury
[ ] [ ] TMJ / jaw problems
[ ] [ ] Migraines
[ ] [ ] Goiter
[ ] [ ] Lumps
[ ] [ ] Pain/stiffness
[ ] [ ] Whiplash injury

Mouth and Throat
C P
[ ] [ ] Bad breath
[ ] [ ] Frequent sore throat
[ ] [ ] Frequent clearing throat
[ ] [ ] Hoarseness
[ ] [ ] Metallic taste in mouth
[ ] [ ] Mouth sores
[ ] [ ] Saliva,excess
[ ] [ ] Sore tongue/lips

Nose/Sinus
C P
[ ] [ ] Hayfever
[ ] [ ] Nosebleeds
[ ] [ ] Red nose
[ ] [ ] Runny nose
[ ] [ ] Sinus problems
[ ] [ ] Stuffy/congestion

Eyes
C P
[ ] [ ] Blurriness
[ ] [ ] Cataracts
[ ] [ ] Color blindness
[ ] [ ] Diminish night vision
[ ] [ ] Dryness, excessive
[ ] [ ] Itchy eyes
[ ] [ ] Eye pain
[ ] [ ] Glasses or contacts
[ ] [ ] Glaucoma
[ ] [ ] Retinal detachment
[ ] [ ] Spots in eyes
[ ] [ ] Tearing, excessive

Ears
C P
[ ] [ ] Dizziness/Vertigo
[ ] [ ] Earache
[ ] [ ] Ear infections
[ ] [ ] Hearing, impaired

Cardiovascular
C P
[ ] [ ] Chest Pain/pressure
[ ] [ ] Fainting/Light-headed
[ ] [ ] Heart Disease
[ ] [ ] High Blood Pressure
[ ] [ ] High Cholesterol
[ ] [ ] Heartbeat, Irregular
[ ] [ ] Heart murmur
[ ] [ ] Palpitations, fluttering
[ ] [ ] Rheumatic fever
[ ] [ ] Swelling in ankles

Respiratory/Pulmonary
C P
[ ] [ ] Asthma
[ ] [ ] Bronchitis
[ ] [ ] Cough, chronic
[ ] [ ] Difficulty breathing
[ ] [ ] Emphysema
[ ] [ ] Pain on breathing
[ ] [ ] Pneumonia
[ ] [ ] Pleurisy
[ ] [ ] Shortness of breath
[ ] [ ] At night
[ ] [ ] Lying down
[ ] [ ] Exercise/exertion
[ ] [ ] Spitting up blood
[ ] [ ] Sputum/mucus
[ ] [ ] Wheezing

[ ] [ ] Teeth grinding
[ ] [ ] Ringing, tinnitus

Past Medical History: Review of Systems (continued)

(Please check the conditions that apply... C = Current and P = Past)

Gastrointestinal

C P
[ ] [ ] Abdom. pain, cramps
[ ] [ ] Belching
[ ] [ ] Blood in stool
[ ] [ ] Change in appetite
[ ] [ ] Change in stool
[ ] [ ] Change in thirst
[ ] [ ] Constipation
[ ] [ ] Diarrhea
[ ] [ ] Fatigue after eating
[ ] [ ] Flatulence/gas
[ ] [ ] Gallbladder disease
[ ] [ ] Heartburn/Reflux
[ ] [ ] Hemorrhoids
[ ] [ ] Hepatitis
[ ] [ ] Jaundice
[ ] [ ] Liver disease
[ ] [ ] Nausea
[ ] [ ] Pain in rectum
[ ] [ ] Painful stool
[ ] [ ] Parasites, diagnosed
[ ] [ ] Stomach pain
[ ] [ ] Trouble swallowing
[ ] [ ] Vomiting
[ ] [ ] Bowel Movements
#/day ___ or #/week ____

Urinary

C P
[ ] [ ] Bedwetting
[ ] [ ] BPH
[ ] [ ] Frequency at night
[ ] [ ] Frequent infections
[ ] [ ] Increased frequency
[ ] [ ] Inability to hold urine
[ ] [ ] Kidney stones
[ ] [ ] Low force urine
[ ] [ ] Pain with urination
[ ] [ ] Urine retention
[ ] [ ] Urgency with urination

Musculoskeletal

C P
[ ] [ ] Arch supports/heel lifts
[ ] [ ] Arthritis
[ ] [ ] Back pain
[ ] [ ] Broken bones
[ ] [ ] Joint pain/stiffness
[ ] [ ] Joint swelling
[ ] [ ] Muscle pain
[ ] [ ] Muscle spasm/cramps
[ ] [ ] Muscle weakness
[ ] [ ] Muscle fatigue
[ ] [ ] Osteoporosis
[ ] [ ] Osteopenia
[ ] [ ] Sciatica

Neurologic

C P
[ ] [ ] Loss of memory
[ ] [ ] Numbness/tingling
[ ] [ ] Paralysis
[ ] [ ] Seizures
[ ] [ ] Tremor

Blood/Peripheral Vascular

C P
[ ] [ ] Anemia
[ ] [ ] Cold Hands/Feet
[ ] [ ] DeepLegPain
[ ] [ ] Easy bleeding/bruising
[ ] [ ] Thrombophlebitis
[ ] [ ] Varicose veins

Skin

C P
[ ] [ ] Acne
[ ] [ ] Boils
[ ] [ ] Cancer
[ ] [ ] Color changes
[ ] [ ] Eczema
[ ] [ ] Flushing
[ ] [ ] Hair loss
[ ] [ ] Hives
[ ] [ ] Itching
[ ] [ ] Lumps
[ ] [ ] Night Sweats
[ ] [ ] Moles
[ ] [ ] Psoriasis
[ ] [ ] Rashes
[ ] [ ] Rosacea
[ ] [ ] Skintags

Mental/Emotional

C P
[ ] [ ] Anxiety
[ ] [ ] Poor memory
[ ] [ ] Depression
[ ] [ ] Concentration
[ ] [ ] Suicidal
[ ] [ ] Critical
[ ] [ ] Loneliness
[ ] [ ] Mood swings
[ ] [ ] Seasonal depression
[ ] [ ] Tension/stress
[ ] [ ] Treatment for mental/emotional concerns

Biologically Male Reproductive (Please check all that apply)

[ ] Birth control type? _____
[ ] Ejaculation concerns
[ ] Fertility concerns
[ ] Genital sores
[ ] Impotence/difficulty or pain having sex
[ ] Penile discharge
[ ] Prostate disease
[ ] Sexually active
[ ] Sexually transmitted infections _____
[ ] Testicular masses
[ ] Testicular pain
[ ] Other biological male concerns _____

Date of last prostate exam? _____
Sexual orientation (mark all that apply): [ ] Heterosexual [ ] Gay [ ] Queer [ ] Bisexual
[ ] Transgender [ ] Abstinent

Biologically Female Reproductive (Please check all that apply)
Age of first menses _____ Average length of blood flow _____(days) What is your typical flow? (Heavy/Light? What size product used? How often changed?) _____
_____
# of days between menstrual cycles _____ (days) Date of last menstruation _____
Are cycles regular? Y / N Are you pregnant? Y / N Age of last period (if menopausal)_____
Mother's age at menopause _____ Date of last annual exam/PAP_____
Do you do self-breast exams? Y / N How often? _____
Please specify # of: Pregnancies_____ Live Births_____ Miscarriages_____ Abortions_____
Sexual orientation (mark all that apply): [ ] Heterosexual [ ] Gay [ ] Queer [ ] Bisexual
[ ] Transgender [ ] Abstinent

Please check all that apply:
[ ] Abnormal PAP (Please describe)_____
[ ] Birth control type? _____ How long used? _____
[ ] Bleeding between cycles
[ ] Breast lumps
[ ] Cervical dysplasia
[ ] Clotting
[ ] Cramping with menses
[ ] DES exposure
[ ] Difficulty getting pregnant
[ ] Endometriosis
[ ] Heavy menstrual flow
[ ] Hormone replacement
[ ] Hysterectomy: [ ] partial [ ] full
[ ] Libido: [ ] Increased [ ] Decreased
[ ] Vaginal discharge
[ ] Irregular cycles
[ ] Menopausal symptoms
[ ] Nipple discharge
[ ] Ovarian cysts/PCOS
[ ] Painful intercourse
[ ] Painful periods
[ ] Sexually transmitted infections _____
[ ] PMS
[ ] Scanty menstrual flow
[ ] Spotting between periods
[ ] Sexually active
[ ] Uterine fibroids