PATIENT TRIAGE

Today's Date:_____

Name:_____ Age:_____ DOB:_____ SS#_____

Address:_____

Email Address:_____ Current Employer:_____

Home Phone:_____ Work:_____ Cell:_____

How did you hear about us? _____

Reason for today's visit:_____

Current Symptoms/Conditions: (check all that apply)

__Seasonal Allergies
__Appetite Poor/Changed
__Constipation
__Night sweats
__Decreased libido
__Dry skin
__Wake up at night
__Memory loss
__Neurological symptoms
__Weight loss
__Headaches
__Excessive thirst//hunger
__Hives/Rashes

__Bruise Easily
__Palpitations
__Diarrhea
__Insomnia
__Sexual dysfunction
__Fatigue
__Irritability
__Mood swings
__Skin problems
__Difficulty losing weight
__Ringing in ears
__Vaginal dryness
__Swelling of extremities

__Anxiety
__Bowel habit change
__Hot flashes
__Joint/Muscle aches
__Dry hair
__Hair loss
__Cravings
__Nausea
__Weight gain
__Wheezing
__Numbness/Tingling
__Urinating often or at night
__Joint pain/stiffness

When did you symptoms start?_____
What makes your symptoms better?_____
What makes your symptoms worse?_____
How long have you had your symptoms?_____
How would you describe your symptoms? Mild? Moderate? Or Severe?_____

G.I. Health Related Questions: (please circle if not all apply)

Do you experience one or fewer bowel movements per day? ____yes _____no

Do you experience fatigue and "foggy thinking"? ___yes ___no

Do you crave sugar; have a bloated abdomen or abdominal pain? ___yes ___no

Do you have recurrent yeast, vaginal, prostate, or urinary tract infections or rashes? ___yes ___no

Do you have a white coating on your tongue or inside your mouth? ___yes ___no

Do you have chronic sinus problems? ___yes ___no

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Do you have itchy rashes on your skin? ___yes ___no

Do you feel 20 to 30 years older than you really are? ___yes ___no

Health Related Questions Continued: (please circle if not all apply)

Does your long struggle for health cause you depression? ___yes ___no

Have you been sent home by doctors who say "nothing is wrong with you" when something is obviously wrong? ___yes ___no

Have you taken repeated or prolonged courses of antibacterial drugs? ___yes ___no

Are you bothered by hormone disturbances, including PMS, menstrual irregularities, sexual dysfunction, sugar cravings, low body temperature or fatigue? ___yes ___no

Are you unusually sensitive to tobacco smoke, perfumes, colognes and other chemical odors? ___yes ___no

Are you bothered by memory or concentration problems? Do you sometimes feel spaced out? ___yes ___no

Have you taken prolonged courses of prednisone or other steroids for more than 3 years? ___yes ___no

Do some foods disagree with you or trigger your symptoms? ___yes ___no

Do you suffer with constipation, diarrhea, bloating, or abdominal pain? ___yes ___no

Does your skin itch, tingle or burn; or is it unusually dry; or are you bothered by rashes? ___yes ___no

Allergies:_____

Medications/Supplements: (please list dosage if possible)

_____

_____

Medical History: (check all that apply):

__Abnormal Pap smear
__Anxiety disorder/Depression
__Breast problems
__Cancer or tumors
__Cervical problems
__Diabetes
__Respiratory problems
__High blood pressure
__Hormone problems
__High cholesterol
__Migraines
__Osteoporosis
__Heartburn
__Prostate Cancer
__Stomach/ Bowel problems
__Stress
__Thyroid disorder
__Tuberculosis
__Endometriosis
__Fibroids

Other:_____

_____

Surgical History: Please list all surgeries that you have had since birth. Include the year the surgery was performed:

_____

_____

Family History:

__Cancer – Which family member(s) and what type(s)?

_____

__Diabetes – Family member(s):

_____

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__Depression – Family member(s):

_____

__Heart Disease/Problems – Family member(s):

_____

__High Blood pressure – Family member(s):

_____

__Other: (please list):

_____

Women Only:

First day of last menstrual cycle:_____ Age first started period:_____ How long do your cycles last?_____

Do you miss your period or have more than one per month? ___yes ____no Are your period regular? ___yes ___no

Any heavy bleeding ? ___yes ___no Do you have a history of infertility? __yes ____no

Are you on birth control? ____yes ____no If yes, what's the name/method? _____

Number of children_____ Number of deliveries___ Number of miscarriages_____ Age at onset of menopause:___

Have you completed menopause? __yes __no Are you pregnant? ____yes ___no

Men Only:

Do you have a history of prostate disease? ___yes____no Have you ever had a elevated PSA? ___yes ____no

Do you have history of prostate enlargement? ___yes___no Do you have a history of prostate cancer? ___yes ___no

Do you have urinary frequency? ____yes ____no

Social History:

Do you drink alcohol? __yes__no If yes how often?_____ Do you exercise? __yes__no How often?_____

What is your marital status? __married__single__divorced__widowed

How many hours of sleep do you get per night?__ Do you take vitamin supplements? __yes__no

Do you drink caffeine?__yes__no If yes, how many cups per day?___ Do you smoke? __yes__no If yes, how many___

Is there any other information you would like us to know that might impact your health; i.e. recent or past stressors?

_____

_____

Patient Signature_____