

Patricia Ammon, MD and Abigail Seaver, ND
160 South Amelia Street – lower level
PO Box 500
Ridgway, Colorado 81432
Phone: 970-626-3188
Fax: 970-626-3187

PATIENT INFORMATION

NAME _____ DATE _____

MALE _____ FEMALE _____ BIRTHDATE _____

SOCIAL SECURITY NUMBER -- OPTIONAL _____

IF CHILD, PARENT'S NAME _____

MAILING ADDRESS: _____

PHYSICAL ADDRESS : _____

PHONE : HOME _____ WORK _____

EMAIL : _____

OCCUPATION/EDUCATION _____

SPOUSE/SIGNIFICANT OTHER _____

CONTACT NAME & PHONE FOR EMERGENCY _____

PRIMARY PHYSICIAN _____ PHONE _____

What are the most important health concerns you have at this time ? Please list in order of importance

Brief Description

When symptoms started

What do you think is causing them ?

1. _____

2. _____

3. _____

4. _____

5. _____

Regarding your chief complaint:

1. Have your symptoms increased or decreased since the onset ? _____

2. What has helped relieve the symptoms ? _____

3. What time of day are your symptoms most severe ? _____

4. How many days per week do you experience your symptoms ? _____

5. How has this problem affected your work home and social life ? _____

6. What type of treatment (medical or non-medical) have you received for this problem ? _____

MEDICATIONS YOU ARE CURRENTLY TAKING

| | Medication | Dosage | Frequency | # of Years Used |
|----|------------|--------|-----------|-----------------|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

(continue on reverse side if necessary)

Number of courses of antibiotics taken : In last 3 years _____ In your life _____

VITAMINS/SUPPLEMENTS YOU ARE NOW TAKING :

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

(continue on reverse side if necessary)

| |
|--|
| TREATMENTS, MEDICATIONS & SUPPLEMENTS used in the past year which were not helpful : |
|--|

- 1.
- 2.
- 3.

| ALLERGIC REACTIONS TO : | SYMPTOMS/REACTIONS |
|---------------------------------|--------------------|
| Drugs: | |
| Foods: | |
| Chemical/Environmental Factors: | |
| Animals: | |

HISTORY OF ILLNESSES/CONDITIONS

PLEASE CIRCLE

- Alzheimer's
- Anemia
- Asthma
- Blood Transfusion
- Cancer –
Type _____
- Chicken Pox
- Diabetes
- Epilepsy
- Heart Disease
- Hepatitis
- Herpes (genital)
- Herpes (oral)
- Herpes (shingles)
- Hypertension

- Kidney Disease
- Mononucleosis
- Pneumonia
- Polio

- Rheumatic Fever
- Rubella (German measles)
- Rubeola (Red measles)
- Scarlet Fever
- Sexually Transmitted Disease
- Stroke
- Thyroid
- Tuberculosis
- Whooping Cough
- Other: _____

HOSPITALIZATIONS / SURGERIES

| Year | Major Event | Hospital | |
|------|-------------|----------|--|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

IMMUNIZATIONS YOU HAVE HAD

- | | |
|------------------------------|--------------------------------|
| ----Chicken pox | ----- Polio injection (Salk) |
| ----Diphtheria/ Tetanus (TD) | ----- Pneumovax |
| ----DPT | ----- Polio oral (Sabin) |
| ----Hepatitis | ----- Rubella (German measles) |
| ----Influenza | ----- Rubeola (Red measles) |
| ----Mumps | ----- Smallpox (vaccination) |
| ----Other : _____ | |

MOST RECENT STUDIES OR TESTS

| <u>TEST</u> | <u>DATE or YEAR</u> |
|------------------------|---------------------|
| Physical Exam | _____ |
| Blood Chemistry/ Count | _____ |
| Cholesterol Test | _____ |
| Urinalysis | _____ |
| Mammogram | _____ |
| Pap Smear | _____ |
| X-ray | _____ |
| CAT Scan | _____ |
| MRI | _____ |
| Ultrasound | _____ |
| Colonoscopy | _____ |
| EKG | _____ |
| TB Test | _____ |
| Other: _____ | _____ |

DIET, EXERCISE & SOCIAL HABITS

Describe your typical exercise regime (frequency/duration) _____

Have you lost or gained more than 10 pounds in the past year ? _____

How much water do you drink in a typical day ? _____

How many times per week do you eat/drink the following :

pop, soft drinks, sweetened beverages

(Gatorade, Sobe, etc) _____

sugar _____

pastries, donuts, cookies, etc _____

candy _____

artificial sweeteners _____

(Nutrisweet, diet pop, etc.)

preserved meats _____

(bacon, hotdogs, lunch meat)

red meat _____

chicken _____

fish _____

milk _____

butter _____

eggs _____

cheese _____

yogurt _____

canned foods _____

cooked vegetables _____

fast food restaurants _____

fresh vegetables _____

garlic _____

onion _____

corn _____

soy products _____

legumes _____

bread _____

wheat _____

white flour _____

coffee _____

tea _____

olive oil _____

other oil _____

margarine _____

| | |
|--------------------------|--|
| Hobbies ? | |
| Travel ? | |
| Drug use ? Which drugs ? | |
| Alcohol consumption ? | |
| Tobacco use ? | |
| Occupational Hazard ? | |

STRESS / TRAUMA Significant Event ? _____

What do you do to cope with stress ? _____

MENTAL / EMOTIONAL HEALTH :

Poor concentration ? _____

Memory problems ? _____

Anxiety / nervousness ? _____

Tension / Stress ? _____

Mood swings ? _____

Depression ? _____

Worrier ? _____

Cry often ? _____

Treated for emotional problems ? _____

Difficulty making decisions ? _____

Do you feel safe in your home ? _____

SLEEP

Hours of sleep per night ? _____

Trouble falling asleep ? _____

Wake in the middle of the night ? _____

Do you fall back asleep easily ? _____

Waking rested ? _____

Chronic fatigue ? _____

Night sweats ? _____7

REVIEW OF SYSTEMS

Name: _____

Date : _____

Please indicate "C" if it is a **current** problem, "P" if it is a **past** problem

BLOOD/ PERIPHERAL VASCULAR

- _____ Easy bruising or bleeding
- _____ Deep leg pain
- _____ Varicose veins
- _____ Anemia
- _____ Cold hands/feet
- _____ Thrombophlebitis

BREASTS

- _____ Lumps
- _____ Nipple discharge
- _____ Pain/tenderness
- _____ Swelling
- _____ Nipple retraction
- _____ Self Exam

CARDIOVASCULAR

- _____ Heart disease
- _____ Blood clots in lungs
- _____ High Blood pressure
- _____ Chest pressure or tightness
- _____ Chest pain (angina) or heaviness
- _____ Palpitations
- _____ Rapid heart rate at rest
- _____ Irregular heart rate
- _____ Heart murmur
- _____ Swollen ankles/ feet in evening
- _____ Leg cramps when sleeping
- _____ High cholesterol or fats
- _____ Blue / cold hands or feet
- _____ Calf pain while walking
- _____ Rheumatic fever
- _____ Phlebitis
- _____ Fainting

- _____ Ear discharge
- _____ Excess wax
- _____ Recurrent infections

ENDOCRINE

- _____ Thyroid problems
- _____ Hypoglycemia
- _____ Excessive thirst
- _____ Fatigue
- _____ Hair loss
- _____ Heat/cold intolerance
- _____ Diabetes
- _____ Excessive hunger
- _____ Easy weight gain

EYES

- _____ Color blindness
- _____ Glaucoma
- _____ Cataracts
- _____ Wear glasses
- _____ "See" spots / stars
- _____ Blurriness
- _____ Double vision
- _____ Tearing/ dryness
- _____ Itchy eyes
- _____ Red eyes
- _____ Strain / pain
- _____ date of last exam

EARS

- _____ Impaired Hearing
- _____ Hearing aids
- _____ Earaches
- _____ Ringing in ears / tinnitus
- _____ Dizziness / vertigo

SKIN

- _____ Color/texture/moisture change
- _____ Sores
- _____ Itching
- _____ Severe acne
- _____ Cancer
- _____ Easy bruising / bleeding
- _____ Change in fingernails
- _____ Hair loss
- _____ Oiliness

LYMPH SYSTEM

- _____ Enlargement
- _____ Redness
- _____ Pain / tenderness

HEAD

- _____ Trauma / injury
- _____ Headache / migraines
- _____ Dizzy or light-headed
- _____ Fainting
- _____ Loss of consciousness
- _____ Feeling of spinning
- _____ Seizure disorder
- _____ Jaw / TMJ problems

IMMUNE

- _____ Chronic Fatigue
- _____ Chronically swollen glands
- _____ Reaction to vaccines
- _____ Chronic infections
- _____ Slow wound healing
- _____ Night sweats

GASTROINTESTINAL / DIGESTION

- _____ Weight loss/gain this year
- _____ Loss of appetite
- _____ Compulsive eater
- _____ Stomach ulcers
- _____ Heartburn
- _____ Indigestion
- _____ Food intolerances
- _____ Bloating or belching
- _____ Flatulence – gas/bloating
- _____ Nausea / vomiting
- _____ Vomiting blood
- _____ Abdominal pain
- _____ Change in stool habits
- _____ Bowel movements in night
- _____ Constipation
- _____ Straining w/bowel movements
- _____ Diarrhea
- _____ Anti-acids / laxatives
- _____ Black stools
- _____ Rectal pain/itching/bleeding
- _____ Hemorrhoids
- _____ Hernia (umbilical or hiatal)
- _____ Yellow skin / Liver disease
- _____ Gall stones
- _____ Pancreatitis
- _____ Colon polyps
- _____ Trouble swallowing

MOUTH & THROAT

- _____ Trauma
- _____ Neck pain / tenderness
- _____ Thyroid problems
- _____ Sores in mouth
- _____ Bleeding / infected gums
- _____ Sore tongue / lips
- _____ Dental cavities
- _____ Teeth grinding
- _____ Frequent sore throat
- _____ Difficulty swallowing

FEMALE REPRODUCTION

- Year of last Pap exam
- Date of last menses
- # days of flow
- Irregular cycles
- Bleeding between cycles
- Cramps
- Clotting
- Flow – scant/normal/excessive
- Vaginal discharge
- Cervical dysplasia
- Endometriosis
- Ovarian cysts
- Uterine fibroids
- Sores on external genitalia
- Infertility problems
- Sexually active
- Age of last menses if menopausal
- Painful intercourse
- Hot flashes
- Vaginal dryness
- Contraceptive use
- # of pregnancies
- # of live births
- Breast feeding
- # of miscarriages
- # of abortions
- Hysterectomy & Age
- Sexually transmitted disease
- Sexual concerns

URINARY TRACT

- Difficulty / inability to urinate
- Pain on urination
- Increased frequency
- Urgency / inability to hold urine
- Frequent infections
- Frequency at night # of times -----
- Kidney stones
- Bladder stones
- Flank pain

MOUTH & THROAT CONT

- Hoarseness
- Change in taste
- Bad breath
- Copious saliva
- Jaw Clicks

MALE REPRODUCTION

- Sexually transmitted disease
- Birth control
- Hernias
- Testicular pain
- Testicular self-exams
- Prostate problems/
enlargement
- Elevated PSA
- Discharge or sores
- Difficulty with urination
- Impotence, sexual concerns

NOSE & SINUSES

- Trauma
- Sinusitis
- Excess nasal drainage
- Post nasal drainage
(in throat)
- Stuffiness / congestion
- Obstruction
- Nosebleed (s)
- Small – loss / change
- Breathe through mouth
- Frequent colds
- Snoring
- Allergies / hay fever

RESPIRATORY

- Asthma
- Pneumonia
- Bronchitis
- Emphysema
- Exposure to tuberculosis 10

URINARY TRACT CONT

- Hernia (L or R) inguinal or femoral
- Cloudy urine
- Dribbling
- Bed Wetting

MUSCULOSKELETAL

- Trauma (fracture/dislocation)
- Car accident
- Blow to the head
- Fall on buttocks
- Decreased range of motion
- Loss of strength
- Stiff or aching muscles/joints
- Neck ache / pain
- Backache / pain
- Arm or hand pain
- Numbness / tingling
- Sciatic pain – right or left
- Arthritis
- Swollen joints
- Joint pain
- Muscle spasms
- Cold hands / feet

RESPIRATORY CONT

- Pleurisy
- Cough
- Pain on breathing
- Wheezing
- Sputum -- irregular
- Cough up blood
- Shortness of breath at rest
- Shortness of breath at
exertion
- Hiccups

NEUROLOGICAL

- Head injury
- Frequent headaches
- Loss of consciousness
- Fainting
- Numbness – where
- Tingling – where
- Weakness – where
- Tremors
- Convulsions / seizures
- Twitching
- Difficulty walking
- Speech abnormalities
- Decrease / loss of sensation
- Poor concentration
- Loss of memory
- Paralysis

FAMILY HISTORY

Have any of your family members (grandparents, siblings, or children) had significant health issues which you would like to state here ?

RELATION

HEALTH ISSUE

ANY OTHER CONCERNS YOU WOULD LIKE TO ADDRESS ?