Health Intake Form

List your top five concerns or reasons for requesting your appointment with Dr. Weiss

1.
2.
3.
4.
5.

Please give any information you think is important regarding these top concerns:

Are there more issues you would like to talk to Dr. Weiss about?
If so list them here:

Medications and Other Drugs

Medications: Include prescription and over the counter medications, birth control allergy medicine pain medicine etc.

Name	Dose/amount	When you take it	Why you take it	Prescribing practitioner

Supplements and Vitamins: Include protein powders, herbs vitamins homeopathics etc.

Name	Dose/amount	When you take it	Why you take it	Prescribing practitioner

Marijuana and non-prescription drugs:

Do you use Marijuana for recreational or medical use? Yes ___ No _____
Form of Marijuana (CDB/THC, smoke, tincture etc.) ____
Reason for using Marijuana ____
Have you ever used nonprescription drugs? Yes ___ No _____ Type used: __________________ Date last used: ________________

Caffeine, and Alcohol:

How much caffeine do you drink daily? ____
Do you drink alcohol? Yes___ No ___
If yes, how much alcohol do you drink weekly? ____
Have you ever tried to:
Cut down?
Quit? Yes __No ___ (if yes list dates of abstinence: ____________________)
Do you have concerns about your alcohol, drug or caffeine use? Yes___ No ___

Allergies Asthma and Eczema

Allergies: Please list any allergies to **food**, **medication**, **supplements** or other **environmental** allergens including animals pollen, latex grass, etc. Onset is when you first noticed it or were diagnosed with it. List what symptoms you get on exposure, such as rash or breathing difficulties. List if the reaction is mild, moderate or severe.

Allergies	**Onset of allergy**	**Reaction**	**Severity of reaction**

Asthma Allergies and Eczema often occur together, and can be a manifestation of a genetic condition have you or a family member ever, even when you were a child, been diagnosed with any of these? If so, list the relationship of the family member any treatment used and if the problem persists or has gone away

	You	Date of diagnosis	Treatment used	Do you still have this?
Asthma - you				
Allergies - you				
Eczema -you				
Asthma – family				
Allergies - family				
Eczema -family				

Past Medical History

List any medical diagnoses you have been given and include if the problem is active or resolved as well as the date of onset. Include ***birth trauma***, ***broken bones, accidents, infections requiring antibiotics, braces or dental work other than cleaning***, and ***treatments*** tried.

Birth to 12 years old

Diagnosis/Health Problem	Age at Diagnosis	Treatments used	Active/Resolved

When you were 13-20 years old

Diagnosis/Health Problem	Age at Diagnosis	Treatments used	Active/Resolved

When you were 21-30 years old

Diagnosis/Health Problem	Age at Diagnosis	Treatments used	Active/Resolved

31years old to-Current

Diagnosis/Health Problem	Age at Diagnosis	Treatments used	Active/Resolved

Past Medical History

Foot health	Comments:
What type of shoes can you wear? (list):	
Do you wear orthotics? Yes____ No____	What Kind?
Do you have foot pain? Yes____No____ Describe:	
Do you have flat feet? Yes____No____	
Do you go barefoot? Yes____ No_____	Does it cause pain to go barefoot? Yes____ No_____

DENTAL HISTORY

Have you ever had a tooth extraction? Yes____ No_____ Date(s)____
Do you have tooth pain? Yes____ No_____ Describe:
Have you ever had a tooth infection? Yes____ No_____ Date of infection_________________
Type of treatment or medication taken ______________________ Is it resolved Yes____ No_____
Have you ever worn braces? Yes____ No_____
Do you wear dentures? Yes____ No_____
Do you wear any dental retainer, orthotics night device plate etc.? Yes____ No_____
Have you ever had Root canal? Yes____ No_____
Have you ever had any other dental or Jaw surgery? Yes____ No_____
Do you have pain when you chew? Yes____ No_____
Does your jaw click? Yes____ No_____
Do you have mercury or amalgam fillings? Yes____ No_____
Do you have a problem with getting dental work? Yes____ No_____

Family History

If a parent or sibling, has any of the following please list which relative and the age at which they were diagnosed:

	Relative	Age at Diagnosis	Comment
Heart Problems:			
High Blood Pressure			
Auto-Immune disease			
Thyroid Disease			
Migraines			

List any other significant health History of your family members. Include your parents, siblings and children. If a family member has died, list what age they died of and if you know, list what the cause of death was in the significant health problem column.

	Alive	Age	M/F	Significant Health Problems
Mother			F	
Father			M	
Sibling				
Sibling				
Child				
Child				

Review of Systems

Mark if you are concerned about any of the following symptoms or body issues and you have not already documented them.

Symptom	X	Comment
Head		
Headaches or head pain		
Changes in vision		
Blurry Vision		
Seeing floaters/stars		
Changes in hearing		
Tinnitus		
Eye or ear discharge		
Red eyes		
Mouth Ulcers		
Nasal Discharge		
Change in voice		
Tooth pain		
Chest/Heart/Lungs		
Shortness of breath with exercise		
Shortness of breath at night or lying down		
Chest pain or pressure		
Palpitations, fluttering, rapid heart beat		
Cough		
Coughing up blood		
Wheezing		
Snoring		
Stopping breathing at night		
Brain/Pscych/Neuro		
Dizziness		
Lightheadedness		
Seizures		
Loss of consciousness/passing out		
Transient loss of function, speech, sight vision		
Balance problems		
Frequent falls		
Confusion		
Memory problems		
Endocrine/Hormones		
Sensitivity to heat or cold		
Hair loss or thinning		
Increased thirst		
Increased appetite		
Immune System		
Fevers or Chills		
Frequent Infections		
Slow healing		
Stomach or digestive system		
Bowel movements		
Digestion		
Reflux		
Bloating or distension		
Heartburn		
Blood in stool or black tarry stoo		
Stomach or abdominal pain		
Trouble swallowing		
Nausea and or vomiting		

Review of Systems

Appetite changes		
Leaky gut/poor absorption		
colitis		
Urinary problems:		
Pain with urination		
Frequent urination		
Weight gain or loss		
Blood in urine		
Increased nighttime urination		
Abnormal discharge		
Incontinence		
Urgency to urinate		
Incomplete emptying with urination		
Skin		
Itching		
Rashes or eczema		
Moles		
Lumps, bumps, sores or bruises		
Discoloration		
Changes in finger or toenails		
Constitutional Symptoms		
Weight Changes		
Changes in appetite		
Changes in Energy		
Fatigue		
Weakness		
Trouble sleeping		
Feeling poorly		
Circulation and Lymphatic		
Ankle swelling		
Pain in legs with exercise		
Chronic pain		
Abnormal bleeding or bruising		
Hypercoagulable		
Musculoskeletal		
Joint pain		
Change in mobility		
Numbness, tingling		
Wounds in feet		
Joint swelling		
Knee pain/swelling		
Hand symptoms		
Elbow symptoms		
Hip Symptoms		
Shoulder Symptoms		
Back aches		
Male Problems		
Erectile dysfunction or libido concern		
Penile pain or discharge, or growth		
Testicular Pain or swelling		
Fertility concern		