Ph: (757) 410-5462

PATIENT INFORMATION FORM

NAME: _____

ADDRESS: _____

_____

_____

HOME TELEPHONE: (_____)_____

CELLULAR TELEPHONE: (_____)_____

WORK TELEPHONE: (_____)_____

EMAIL ADDRESS: _____

BIRTHDATE: _____/_____/_____

NAME OF PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT: _____PHONE:_____

REASON FOR VISIT: _____

How did you hear about us (please check):
Wife _____ Internet_____ Friend_____ Other _____

Synergy Integrative Medical Center
Patient Intake form for Men **MR#** _____

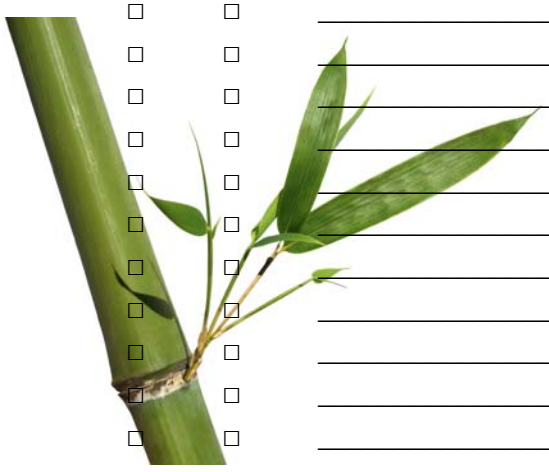
Name _____ **age**_____ **Date** _____

Primary Care Doctor _____ **Referred by** _____

Concern(s): Please rank by priority Example: Headaches	**Onset** 2 years ago	**Frequency** 2x/wk	**Severity** mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

What are your goals for this visit? _____
_____
_____
_____

Illnesses – yours & your family's	**Self**	**Family**	**List family members who have had these illnesses**
Heart Disease	☐	☐	_____
High blood pressure	☐	☐	_____
Cancer	☐	☐	_____
Stroke	☐	☐	_____
Diabetes	☐	☐	_____
Lung disease	☐	☐	_____
Hepatitis	☐	☐	_____
Digestive diseases	☐	☐	_____
Seizures	☐	☐	_____
Thyroid disease	☐	☐	_____
Mental disorders	☐	☐	_____
Osteoporosis	☐	☐	_____
Other _____	☐	☐	_____
Other _____	☐	☐	_____



Have you fathered any pregnancies? ____ yes ___ no

Is infertility a concern for you? ____ yes ___no

Operations **Injuries**

What	When	What	When

Please list all medications, vitamins, herbs and supplements which you now take regularly, prescribed or over-the-counter.

Name & dosage	**Reason**	**When started**	**Who recommended**

Allergies or intolerances to medicines:

Medication	Reaction/intolerance symptoms

Occupation, or previous occupation if retired: _____

What interests/hobbies do you have? _____

_____

_____

With whom do you live?

Name	Age	Relationship	Name	Age	Relationship

What physical activity do you do? _____

_____

What are the major stressors in your life? _____

_____

_____

What do you do to relax? (or what would you like to do?) _____

_____

_____

Religious affiliation _____

What prior experiences have you had with complementary and alternative medicine? _____

_____

_____

Tobacco use: □ never used □smoked from age ___ to ___ . ____ packs per day.

Alcohol use: □ never used □estimated ____ drinks per week.

□ history of alcohol abuse

Recreational drugs: □ never used □ type _____

Health screening:

Have you had?	No	Yes	Date of most recent	Who ordered/performed
PSA				
Colonoscopy				
Prostate exam				
Bone density test				
Cholesterol test				

Review of symptoms:

Sleep _____ hrs/night sleep problems _____do you have sleep apnea? y n

Hair problems _____

Erection problems/impotence/ED y n

Do you have erections while sleeping or in the morning? y n

Other sexual problems (list) _____

Intolerance to heat or cold (circle if applicable)

Fatigue y n

Dry skin y n

Frequent or severe headaches y n

Weight loss y n Weight gain y n

Swelling y n describe _____

Palpitations y n

Breast enlargement y n

Frequent crying or depression y n

Weakness y n

Joint pain y n

Muscle problems y n

Stomach/bowel problems y n describe _____

Urinary problems y n describe _____

NUTRITION EVALUATION

Dietary intake. Please list **all** food and drinks you have consumed in the past 24 hours. Be honest – don't write what you think we want to hear. You're only hurting yourself.

Food or drink **how prepared (baked, fried, etc)** **amount (cups, tbsp, ounces, etc)**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Any food you avoid, and why _____

_____

Was this a typical day? If not, why not? _____

_____

_____