www.AtlantisMediSpa.com
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Date: _____ Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Occupation: _____ Work Phone: _____

Person to contact in case of emergency: _____

Reason for consultation: _____

How Did You Hear About Us? (friend, website, specific ad, another physician): _____

List all Medications and Supplements you are currently taking or should be taking: _____

_____

_____

Please check (√) any of the following that you take:

□ Antacids (Rolaids, Tums)
□ Antihistamines (Claritin, Benadryl)
□ Cortisone (cream or pills)
□ Cough & cold medications
□ Diet pills, appetite suppressants
□ Laxatives
□ Oral contraceptives or HRT
□ Pain relievers (aspirin, Tylenol, Aleve, Motrin)
□ Sleeping pills
□ Thyroid medication

List all medication and food allergies: _____

_____

_____

What diagnostic imaging studies have you had?

□ Bone Density Scan (DXA)
□ Colonoscopy/Sigmoidoscopy
□ CT Scan
□ Endoscopy
□ Electrocardiogram (ECG/EKG)
□ Electroencephalogram (EEG)
□ Echocardiogram (Echo)
□ Laparoscopy
□ Mammogram
□ MRI
□ Ultrasound
□ X- ray
□ Other_____

What immunizations have you had? Include international travel vaccinations if applicable.

□ Diphtheria
□ Diphtheria, Tetanus
□ Diphtheria, Tetanus, Pertussis
□ Tetanus, single
□ Haemophilus Influenza type b
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Influenza (flu shot)
□ Measles, single
□ Mumps, single
□ Measles, Mumps, Rubells (MMR)
□ Polio - □ inactive (IPV)
□ Oral (OPV)
□ Rubella, single
□ Varicella (Chicken Pox)
□ Other _____

Name: _____

List in ORDER OF IMPORTANCE your top 4 health concerns and how long you have had these concerns:

1. _____

2. _____

3. _____

4. _____

What do you believe is the cause of condition #1? _____

_____

When was your last visit to the doctor's office, medical clinic or hospital and what was the reason for the visit?

_____

_____

Date of Last Physical Exam? _____

PAST MEDICAL HISTORY

Please mark **P** *(past)* or **C** *(current)* for any of the following that you or your family members have had:

Condition	Self	Father	Mother	Sibling(s)	Aunt/Uncle	Grandparent	Child
ADD/ADHD							
Alcoholism							
Allergies							
Anemia/ Blood Disorder							
Anxiety/Depression							
Arthritis							
Asthma							
Autoimmune Disease							
Blood Vessel Disorder							
Cancer (type)							
Chemical Sensitivities							
Diabetes							
Drug/Other Addiction							
Eating Disorder							
Epilepsy/Seizures							
Food Poisoning (type)							
Gallbladder Disease							
Gastrointestinal Disorder							
Glaucoma/Cataracts							
Gout							
Gum Disease							
Headaches/Migraines							
Heart Attack							
Heart Disease							
Heart Murmur							
High Blood Pressure							
Hypoglycemia							
Infertility							

Name: _____

PAST MEDICAL HISTORY (CONTINUED)

Please mark **P** *(past)* or **C** *(current)* for any of the following that you or your family members have had:

Condition	Self	Father	Mother	Sibling(s)	Aunt/Uncle	Grandparent	Child
Kidney Disease							
Liver Disease							
Lung Disease							
Menstrual Disorder							
Mental Illness							
Mouth, Throat Disease							
Muscular Disorder							
Neurological Disorder							
Obesity							
Pain, Chronic							
Skeletal Disorder							
Skin Disorder							
Stroke							
Thyroid Disorder							
Tuberculosis							
Ulcer							
Urinary Disorder							
Vision Problems							
Yeast Infections							

Family's Health	Father	Mother	Sibling (s)	Grandparents
Good				
Average				
Poor				
Age, if living				
Age, when deceased				
Cause of death				

All Past Surgeries you have had and approximate month/year of the surgeries: _____

_____

_____

_____

REVIEW OF SYSTEMS

Please check (√) the box for any conditions that you currently experience - □ for *Current*, O for *Past*

Neurologic
C P
□ O Loss of memory
□ O Numbness or tingling
□ O Paralysis
□ O Seizures
□ O Tremor

Neck
C P
□ O Goiter
□ O Lumps
□ O Pain or stiffness
□ O Whiplash injury

Ears
□ O Dizziness/Vertigo
□ O Earache
□ O Ear infections
□ O Ears, itchy
□ O Hearing, impaired
□ O Ringing, tinnitus
□ O Wax, excessive

Name: _____

REVIEW OF SYSTEMS

Please check (√) the box for any conditions that you currently experience - □ for *Current*, O for *Past*

Blood/ Peripheral Vascular
C P
□ O Anemia
□ O Cold hands/feet
□ O Deep leg pain
□ O Easy bleeding/ bruising
□ O Thrombophlebitis
□ O Varicose veins

Cardiovascular
C P
□ O Chest pain/pressure
□ O Fainting/ Light-headed
□ O Heat Disease
□ O High blood pressure
□ O High cholesterol
□ O Heart beat, irregular
□ O Heart murmur
□ O Palpitations, fluttering
□ O Rheumatic fever
□ O Swelling in ankles

Musculoskeletal
C P
□ O Arch supports/heel lifts
□ O Arthritis
□ O Back pain
□ O Broken bones
□ O Joint pain or stiffness
□ O Joint swelling
□ O Muscle pain
□ O Muscle spasms/cramps
□ O Muscle weakness, tiredness
□ O Osteoporosis/osteopenia
□ O Sciatica

Head
C P
□ O Headaches
□ O Head injury
□ O Jaw; TMJ problems
□ O Migraines

Skin
C P
□ O Acne
□ O Boils
□ O Cancer
□ O Color change
□ O Eczema
□ O Flushing/hot flashes
□ O Hair loss
□ O Hives
□ O Itching
□ O Lumps
□ O Night sweats
□ O Moles
□ O Psoriasis
□ O Rashes
□ O Rosacea
□ O Skin Tag

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

Gastrointestinal
C P
□ O Abdominal pain, cramps
□ O Alternating diarrhea/constipation
□ O Belching
□ O Blood in stool
□ O Change in stool
□ O Bowel movements, how often?
#___ per day/ 2days/ 3 days/ week
□ O Bulimia
□ O Change in appetite
□ O Change in thirst
□ O Constipation
□ O Diarrhea
□ O Fatigue after eating
□ O Flatulence/gas
□ O Gallbladder disease
□ O Heartburn
□ O Hemorrhoids
□ O Hepatitis
□ O Jaundice
□ O Liver disease
□ O Nausea
□ O Pain in rectum
□ O Painful stool
□ O Parasites, diagnosed
□ O Reflux
□ O Stomach pain
□ O Trouble swallowing
□ O Vomiting

Mouth and Throat
□ O Bad breath
□ O Dental cavities/fillings
□ O Dentures
□ O Frequent sore throat
□ O Frequently clearing throat
□ O Gum problems
□ O Hoarseness
□ O Metallic taste in mouth
□ O Mouth sores
□ O Saliva, excess
□ O Sore tongue, lips
□ O Teeth grinding

Name: _____

REVIEW OF SYSTEMS

Please check (√) the box for any conditions that you currently experience - □ for *Current*, O for *Past*

Urinary
C P
□ O Bed wetting
□ O BPH
□ O Frequency at night
□ O Frequent infections
□ O Increased frequency
□ O Inability to hold urine
□ O Kidney stones
□ O Kidney, back pain
□ O Low force of urine
□ O Pain with urination
□ O Urine retention
□ O Urgency with urination

Mental/Emotional
C P
□ O Anxiety, nervousness
□ O Poor memory
□ O Depression
□ O Concentration, difficult
□ O Contemplate suicide
□ O Critical of others
□ O Critical of self
□ O Experience loneliness
□ O Mood swings
□ O Tension, stress
□ O Treatment for mental/emotional concerns

Nose and Sinuses
C P
□ O Hay fever
□ O Nose bleeds
□ O Red nose
□ O Runny nose
□ O Sinus problems
□ O Stuffiness, congestion

Respiratory
C P
□ O Asthma
□ O Bronchitis
□ O Cough, chronic
□ O Difficulty breathing
□ O Emphysema
□ O Pain on breathing
□ O Pneumonia
□ O Pleurisy
□ O Shortness of breath
□ O At night
□ O Lying down
□ O With exercise/exertion
□ O Spitting up blood
□ O Sputum
□ O Wheezing

REPRODUCTIVE, MALE

Please check (√) the box for any which apply to you:

□ Birth control, type? _____
□ BPH
□ Ejaculation concerns
□ Fertility concerns
□ Impotence
□ Penile discharge
□ Penile sores
□ Prostate disease
□ Sexually active
□ Sexual difficulties
□ Sexually transmitted infection(s) _____
□ Testicular masses
□ Testicular pain
Date of last prostate exam? _____

Sexual orientation *(circle)*: Men/Women/Bisexual Transgender: Yes No

REPRODUCTIVE, FEMALE

Age of first menses _____ Avg. length of blood flow _____ (days)

Number of days between menstrual cycles _____(days) Date of last menstrual period _____

Are cycles regular? Yes No Are you pregnant? Yes No Age of last period (if menopausal) _____

Mother's age at menopause _____ Date of last annual exam/PAP _____

Do you do self-breast exam? Yes How often? _____

Please specify number of:

Pregnancies _____ Live Births _____Miscarriages _____ Abortions _____

Sexual orientation *(circle)*: Men/Women/Bisexual Transgender: Yes No

Name: _____

Please check (√) the box for any which apply to you:

□ Abnormal PAP
□ Birth control, type? _____
□ Bleeding between cycles
□ Breast lumps, fibrocystic changes
□ Cervical dysplasia
□ Clotting
□ Cramping with menses
□ DES exposure
□ Difficulty getting pregnant
□ Endometriosis
□ Genital warts
□ Heavy menstrual flow
□ Hormone replacement therapy
□ Hysterectomy, oophorectomy
□ Hysterectomy, ovaries intact
□ Increased or decreased libido
□ Irregular cycles
□ Menopausal symptoms
□ Nipple discharge
□ Other _____
□ Ovarian cysts/PCOS
□ Painful intercourse
□ Painful periods
□ Premenstrual Syndrome (PMS)
□ Scanty menstrual flow
□ Spotting between periods
□ Sexual difficulties
□ Sexually active
□ Sexually transmitted infection _____
□ Uterine fibroids
□ Vaginal discharge

SOCIAL HISTORY

Occupation _____ *(circle)* Full Time /Part Time /Student /Retired/Disability

Employer/School _____

Are you currently: *(circle)* Single/Married/Long – term relationship/Widowed/Divorced/Other _____

Name of partner: _____ Number of children and ages? _____

Have you traveled outside the US? Yes No *If yes*, where? _____When? _____

Describe your support network: _____

_____

Have you ever been abused or assaulted verbally, sexually, or physically? Yes No

Health Habits Yes No If Yes, for how long and/or how often per week?

Do you exercise? Yes No
Do you smoke tobacco? Yes No
Past or present use? _____
Do you drink alcohol? Yes No
If, so circle one: Daily Occasionally Rarely
Do you use recreational drugs? Yes No
Have you ever been treated for drug/alcohol dependence? Yes No Explain:_____
Do you drink coffee, soda or black tea? Yes No
Do you drink "diet" sodas or eat "diet" foods? Yes No
Are you familiar with "safe sex practices"? Yes No
Do you follow a spiritual practice? Yes No
Do you have any hobbies/ interests? Yes No
Describe:_____

General Review

Sleep well? Yes No
Wake feeling rested? Yes No
Current weight _____
Weight one year ago _____
Max adult weight, _____ Date _____
Min adult weight, _____ Date _____
Max adult height _____
Eat three meals daily? Yes No
Enjoy your work? Yes No
Spend time outside? Yes No
Take vacations? Yes No
Best energy level? (time of day) _____
Lowest energy level? (time of day) _____
Watch television? Yes No Hours/week _____
Read? Yes No Hours per week _____
Subjectively, do you feel your temperature runs warm or cool? _____
Use a computer? Yes No Hours per day? _____
Are you a morning, afternoon or night person? _____

Name: _____

FOOD & DIET

Please describe your typical food intake: _____

_____

_____

_____

_____

Breakfast Lunch Dinner Snacks Beverages

Approximate Amount of Water a Day _____ Filtered? Yes No

List the 3 healthiest foods you eat during an average week: _____

List the 3 worst foods you eat during an average week: _____

What are your favorite foods?_____

_____

What are your least favorite foods? _____

_____

What is your favorite meat? _____ Vegetable?_____ Fruit? _____ Drink? _____

Do you consider yourself a picky or an adventurous eater? _____

What flavors do you like? *(circle)* sweet/salty/bitter/sour/aromatic/spicy/bland

Do you follow a certain type of diet? Yes No Please explain. _____

Have you or do you regularly fast? Yes No Please explain. _____

Do you drink sodas of any kind? Yes No If so occasionally or daily? _____

Do you eat breakfast? Yes No Do you skip meals? Yes No

When are the hungriest in your typical day? _____

Do you eat out/purchase your meals more than 3 times a week? Yes No If so how many days a week? _____

Are you an emotional eater? Yes No Do you binge eat? Yes No

Do you or have you ever had an eating disorder? Yes No If 'yes', please explain. _____

_____

Goal Weight_____

Is there a particular event you are preparing for? Yes No If so, what is the event and when is it? _____

_____

Name: _____

What diets have you followed in the past? _____

_____

Physical Activity (circle one):

Cardio Exercise Strength Training No exercise at all

Circle one: Once a week 2 to 3 times a week 3 to 4 times a week More than 5 times a week

Your Daily activity Level: Sedentary 1 2 3 4 5 6 7 8 9 10 Very Active

Do you have a physical condition that limits your exercise activity? Yes No

If so what is that limitation? _____

General Wellness:

Stress Level (circle one): Total relaxation 1 2 3 4 5 6 7 8 9 10 Suicidal

HEALTH GOALS

What are you health goals? _____

_____

What is your level of motivation regarding your healing? _____

_____

What do you expect from your practitioner? _____

_____