Durango Natural Medicine

Welcome to Durango Natural Medicine!
Please fill out and bring along to your first appointment.

Durango Natural Medicine

"Invoking the Healing Power of Nature"

Dr. Nancy Utter, ND

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Patient Note: This is a confidential record of your medical history. It will not be released except when you have authorized me to do so. Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Mark anything that you do not understand with a question mark. Thank you.

Name: _____ Date: _____ Date of Birth:_____

Address: _____

Email: _____ Occupation: _____ Age: _____

Would you like to be on our email list? Y N (Never given out to any other person or business.)

Telephone Home: _____ Work: _____ Mobile: _____

Emergency Contact Name: _____ Phone: _____ Relation:_____

Spouse/Partner Name: _____

Children Names & Ages:_____

Do you have health insurance with alternative medical coverage? Y N

How did you hear about Durango Natural Medicine? _____

Other healthcare providers:

1. Name: _____ Profession: _____

   Phone: _____ Fax: _____

2. Name: _____ Profession:_____

Phone: _____ Fax: _____

Health Information

Please list your health concerns (physical, emotional, or psychological) in order of importance to you, and the date of onset:

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

5. _____ _____

6. _____ _____

Anything further: _____

_____

Please list your most stressful life experiences (physical or psychological):

1. _____Age: _____

2. _____Age: _____

3. _____Age: _____

4. _____Age: _____

5. _____Age: _____

Anything further: _____

_____

Supplements & Medications

Please list all **current** vitamins/minerals, herbs, or homeopathic remedies, along with the daily dose, and how long you have taken it.

Supplement	Dose/day	How long	Reason for Supplement?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all **current** medications (prescription and over-the-counter), the daily dose, how long you have taken it, and the reason for the medication.

Medication	Dose/day	How long	Reason for Medication?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are the medications well tolerated? Y N If no, please list the adverse reactions or side effects and from what medication:

_____

_____

In the last 10 years, approximately how many courses of antibiotics have you taken? _____

Medical History

Please indicate if you have had any of the following diagnostic tests performed:

	Test	Notable Finding		Test	Notable Finding
☐	Thyroid Panel	_____	☐	Cholesterol	_____
☐	Liver Panel	_____	☐	DEXA Scan	_____
☐	Complete blood count	_____	☐	EKG	_____
☐	Blood sugar test	_____	☐	Chest x-ray	_____
☐	Colonoscopy	_____	☐	Mammography	_____
☐	Food Allergy	_____	☐	Thermography	_____

☐ Heavy Metals _____
☐ Digestive Stool Analysis _____
☐ Hormone level _____
☐ Adrenal Function _____
☐ other _____

Date of last physical exam: _____ Findings: _____

_____

Please list any past **surgeries or hospitalizations** with approximate dates:

_____ _____

_____ _____

_____ _____

Please list all **past injuries** (ie. broken bones, joint sprains, burns, falls, car accidents, etc.) with dates:

_____ _____

_____ _____

_____ _____

List all **dental work** and the approximate date of the procedure (root canal, mercury or ceramic filling, implants, caps, dentures):

_____ _____

_____ _____

_____ _____

What is your blood type? A+ B+ O+ AB+ A- B- O- AB-

Height: _____ Current weight: _____ Weight 1 yr. ago: _____ Max weight: _____ When? _____
Desired weight: _____
Indicate if you had any of the following:

Childhood Illness

☐ Asthma
☐ Chickenpox
☐ Eczema
☐ Frequent ear infections or colds
☐ Measles
☐ Mumps
☐ Polio
☐ Rubella
☐ Rheumatic fever
☐ Scarlet fever
☐ Whooping cough
☐ Shingles

Vaccination History

☐ Measles
☐ Hepatitus A
☐ Hepatitus B
☐ Tetanus
☐ Small pox
☐ Diphtheria
☐ Mumps
☐ Flu Shot
☐ Chicken pox
☐ Pertussis
☐ Rubella
☐ Polio

Other Medical Procedures

☐ Joint replacement
☐ Pacemaker
☐ Pins or plates

Review of Systems

Circle if the symptom has occurred in the **last year**. Place a **check mark** if the symptom has occurred in the **past.**

General	weight gain weight loss significant wt. loss significant wt. gain history of dieting	chronic fatigue afternoon fatigue weakness excessive thirst anemia	spontaneous swelling night sweats fever/chills sick more than 1 time/yr	intolerance to heat intolerance to cold cold hands/feet other:
Skin	dry skin itchy skin rashes hives moist skin bruising easily	acne eczema psoriasis shingles ringworm	athlete's foot moles bumpy skin on back of arms spider/varicose veins	changes to nails changes to skin color changes to moles nail fungus nail ridges other:
Head	headaches migraines	dizziness vertigo	trauma hair loss	other:
Eyes	dry eyes watery eyes itchy eyes eye pain red eyes discharge from eyes	floaters/hallo/flashes blurred vision impaired vision double vision eyes sensitive to light poor night vision	sties cataracts vision loss other	vision correction: _____ vision: near -or- far contacts glasses laser
Ears	ear pain itchy ears waxy ears	discharge from ears ringing in ears hearing loss	ear infections ear infections as a child	hearing aids other:
Nose & Sinuses	itchy nose discharge from nose congested nose/sinuses	postnasal drip nosebleeds loss of smell	breathes thru mouth snores	other:
Mouth & Throat	Dry mouth itchy mouth/throat sores on mouth/lips hay fever/allergies bad breath root canals	frequent sore throat coughing up blood persistent cough difficulty swallowing loss of taste hoarseness	dentures inflamed/bleeding gums cavities braces teeth sensitivity	jaw clicks TMJ other dental concerns... treatment for strep as a child... other:
Neck	neck pain or stiffness	swollen glands	trauma	other:

Respiratory	shortness of breath wheezing pain with breathing chronic cough coughing up blood	asthma allergies bronchitis/pneumonia positive TB test history of smoking	exposure to chemicals exposure to solvents exposure to particulates	history of 2nd hand smoke other:

Circle if the symptom has occurred in the **last year**. Place a **check mark** if the symptom has occurred in the **past.**

Cardio-vascular	high blood pressure low blood pressure high cholesterol high glucose chest pain heaviness in legs cold hands/feet	feel heart racing chest tightness difficulty breathing at night palpitations swelling in ankles heart fluttering	Purple fingers/lips irregular heartbeat heart murmur dizziness on standing exhaustion with minor exertion	varicose veins hemorrhoids spider veins calf pain at night calf pain walking other:
Gastro-intestinal	poor appetite excessive appetite changes in appetite excessive thirst trouble swallowing stomach pain nausea / vomiting vomit blood burping / belching abdominal pain abdominal bloating gas /flatulence	indigestion heartburn / antacid use constipation – i.e. (<1 stool/d) stool hard to pass foul smelling stools loose stools (break up when hit water) diarrhea blood in stools black tar in stools mucous in stools undigested food in stools	stool shape: - one piece - hard little pellets - breaks up in water - other: Color: - yellow - green - light brown - dark brown - black	intolerance to specific foods: fatigue after eating food sensitivity anal itching liver disease gallbladder disease treated for parasites ulcers hemorrhoids other:
Endocrine	hypothyroid hyperthyroid hypoglycemia excessive thirst	heat or cold intolerance diabetes fatigue	poor appetite excessive hunger seasonal depression	unexplained wt loss easy wt gain other:
Immune	slow wound healing reactions to vaccinations	chronic fatigue syndrome	chronically swollen glands	chronic infections other:
Neurological	fainting dizziness / vertigo numbness or tingling trembling hands	head trauma poor concentration memory loss lack of alertness	loss of grip strength loss of muscle tone muscle weakness head heavy heavy extremities	other:
Urinary	frequent urination urinate <3 times/day can't hold urine urination with cough or sneeze	light yellow urine yellow urine yellow dark urine red urine cloudy urine strong smelling urine	kidney infections bladder infections urination at night pain/burning urination	dripping after urination bed-wetting other:

Musculo-skeletal	pain in: - arms - hands - shoulders - neck - upper back - lower back - hips - legs	painful bones tight shoulder muscles swollen knees/elbows numbness / tingling burning spasms/cramps morning stiffness	chronic pain loss of height unable to sit straight activities limited due to pain	arthritis herniated/slipped disk tendonitis osteoporosis broken bone other:

Circle if the symptom has occurred in the **last year**. Place a **check mark** if the symptom has occurred in the **past.**

Women only	age of first menses:_____ length of period:_____ length of cycle:_____ date of last menses:_____ heaviest flow day:_____ # of pads/tampons on heaviest day:_____ abnormal pap	# pregnancies: _____ # live births:_____ sexually active Y N which gender are you sexually active with: - men - women - both type of birth control: type of STD control: - condoms - monogamy - other:	spotting between periods clots with period menstrual cramps wt gain with period PMS irritability moodiness crave sweets tendency to cry bloating / swelling breast tenderness low back pain fatigue with period missed periods irregular periods difficulty conceiving lack of sexual desire	vaginal itching vaginal discharge vaginal odor yeast infections vagina mucosa dry painful intercourse painful masturbation history of STDs Y N tested for STDs Y N uterine cyst/fibroids hysterectomy Use of birth control pill for greater than 10 yrs?
Women only	monthly breast self-exam Y N fibrous breast breast feed your child breast implants history of mammograms abnormal mammogram nipple discharge	hot flashes vaginal dryness changes in cycle moodiness brain fog menopause age of menopause: ____	use of hormone replace-ment:	other:
Men only	sense of full bladder difficulty urinating burning/pain with urination wake up to urinate dripping after urination increased straining with urination	discharge from penis sore on penis history of STDs Y N tested for STDs Y N premature ejaculation painful ejaculation erectile dysfunction infertile lack of sexual drive sexual difficulties	testicular lump testicular pain breast lump monthly testicular/breast self-exam? Y N history of prostatitis enlarged prostate prostate exam? Y N PSA test? Y N prostate cancer pain/cold in genital area hernias	currently sexually active? Y N Which gender are you sexually active with: -men - women - both type of birth control: type of STD control: - condoms - monogamy - other:

Emotional	depression mood swings	treated for emotions tension	suicidal thoughts anxiety/nervousness	other:

Family History

Please indicate whether any **family members** have had any of the following:
(Include parents, siblings, maternal grandparents (MGP), paternal grandparents (PGP), aunts, uncles. Include age and cause of death if applicable.)

	Relation to you		**Relation to you**
☐ Alcoholism	_____	☐ Diabetes	_____
☐ Allergies	_____	☐ Drug abuse	_____
☐ Alzheimer's disease	_____	☐ Heart disease	_____
☐ Arthritis	_____	☐ High Blood Pressure	_____
☐ Asthma	_____	☐ Kidney disease	_____
☐ Cancer (indicate type)	_____	☐ Osteoporosis	_____
☐ Depression	_____	☐ Stroke	_____
☐ Epilepsy	_____	☐ Thyroid condition	_____
☐ Autoimmune condition	_____	☐ Anemia	_____
☐ Skin condition	_____	☐ Glaucoma	_____
☐ Tuberculosis	_____	☐ Other medical illness	_____

Activities of Daily Living

Activity	How often per day, week, month, ever, or never	Activity	How often per day, week, month, ever, or never	Activity	How often per day, week, month, ever, or never
Coffee / black tea		# meals /day		# hours sleep	
Soda		# 8oz. water / day		Once up, feel rested	
Tobacco		eat red meat		difficulty going to sleep	
Alcohol		eat chicken		difficulty staying asleep	
Recreational drugs		eat fish		difficulty waking up	
physical activity / exercise		eat fresh vegetables		take time for yourself	
drive w seat belt		eat fruit		watch TV	
brush teeth		eat dairy products		participate in friendships, community, support groups	
dental floss		eat refined wheat		# hours in car or bus	
wear sunscreen		eat products with sugar added		sexually active with self or partner	
chemical exposure		eat whole grains		contraception	
# hrs / wk at work		# bowel movements		# sexual partners	
# vacations / year		# times urinate		does a condition limit your activities?	
cellphone use		sleep with electric blanket		exposed to pets or animals	
exposed to mold		exposed to heavy metals		exposed to radiation: x-ray / CT / PET / mammo / EEG / ECG / MRI / etc.	

Please list all Allergies (food, medication, environmental): _____

_____

Please describe the emotional climate of your home: _____

_____

_____

Rate your stress level (1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Which factors most contribute to your stress?

☐ health ☐ work ☐ money ☐ family ☐ marriage

Please describe: _____

_____

_____

In your everyday life, your present faith/spiritual practices are (1=unimportant, 10=very important):

1 2 3 4 5 6 7 8 9 10

Please rate your level of motivation to affect change in your health (1=unmotivated, 10=highly motivated):

1 2 3 4 5 6 7 8 9 10

What brings you joy? _____

_____

Any additional information about your health that you would like to share: _____

_____

_____

Thank you for taking the time to fill out this Health intake form. This information will greatly assist us in helping you achieve your health and wellness goals. All information is strictly confidential as required by law and the privacy policy of this practice.

Diet Diary

Please fill out 3 days worth and bring to your appointment or when you return the whole Intake Form.
Guidelines: Write down EVERYTHING you eat and drink for meals and snacks. List BRAND NAMES of foods you bought. List EXACT INGREDIENTS of home-made food. The purpose is not to judge your eating habits, but to learn more about your nutritional, biochemical, hormonal needs and strengths. Under BM, please list the time you had a bowel movement and if it was D (diarrhea) and/or C (constipation).
Record type and amount of insulin injected (if pertinent).

Name:_____

Breakfast times	Lunch times	Dinner times	Symptoms times	BM times
Day 1				
Day 2				
Day 3				

Environmental Illness Questionnaire (if applicable)

When did you last feel well? _____

What changes in your life occurred before that time? _____

_____

What do you think has precipitated your condition? _____

_____

Are you exposed to solvents, pesticides or mold? _____

_____

Did you renovate your home, or get new kitchen cabinets or carpeting?

_____

Have you changed jobs or had less ventilation at work or a new copier or computer installed? Are other's sick – even if the symptoms are different?

_____

Are you sensitive to perfume, diesel exhaust or the detergent aisle of the grocery store?

_____

Do other chemicals, newspapers, the mail bother you? (sleepy? Headaches?)

_____

Do you feel better outside in fresh air? _____

Do you fall asleep or get a headache in traffic, feel exhausted in stores, tire centers, or moldy buildings?

_____

Are you better on the weekends and worse on return to work? _____

Do you have a moldy basement or does the house smell musty when you first come home?

_____

Before a headache or other reaction – What did you just eat, touch or smell?

_____

Have you been avoiding dealing with a water leak? _____

Do you have a crawlspace?

_____

Are you worst in the winter when inside more and the windows are closed?

_____

Dizzy on standing from bending over recently? _____

Do you have insomnia? _____

What part of the year gives you the most trouble? _____

Do you have symptoms in many different areas? _____

Do people think you are a hypochondriac? _____

Can you tell you have a physiologic, not a mental problem? _____

Do others think you have mental difficulties and that you tolerate stress very poorly?

_____

Do you have short-term memory loss? _____

Do you feel you are definitely ill but no one can figure out why? _____

Are you intolerant of electrical appliances and/or fluorescent lights? _____

Does your cell phone heat up in your hand or give you a headache? _____

Do you use Tide, Downey or Bounce? _____

Cancellation Policy

New patient appointments must be cancelled 48 business hours (Monday-Friday) in advance or they will be billed. A first office visit that is not cancelled 48 hours in advance will be charged $145.00.

All appointments for established patients must be cancelled 24 business hours (Monday-Friday) in advance or they will be charged the full appointment fee.

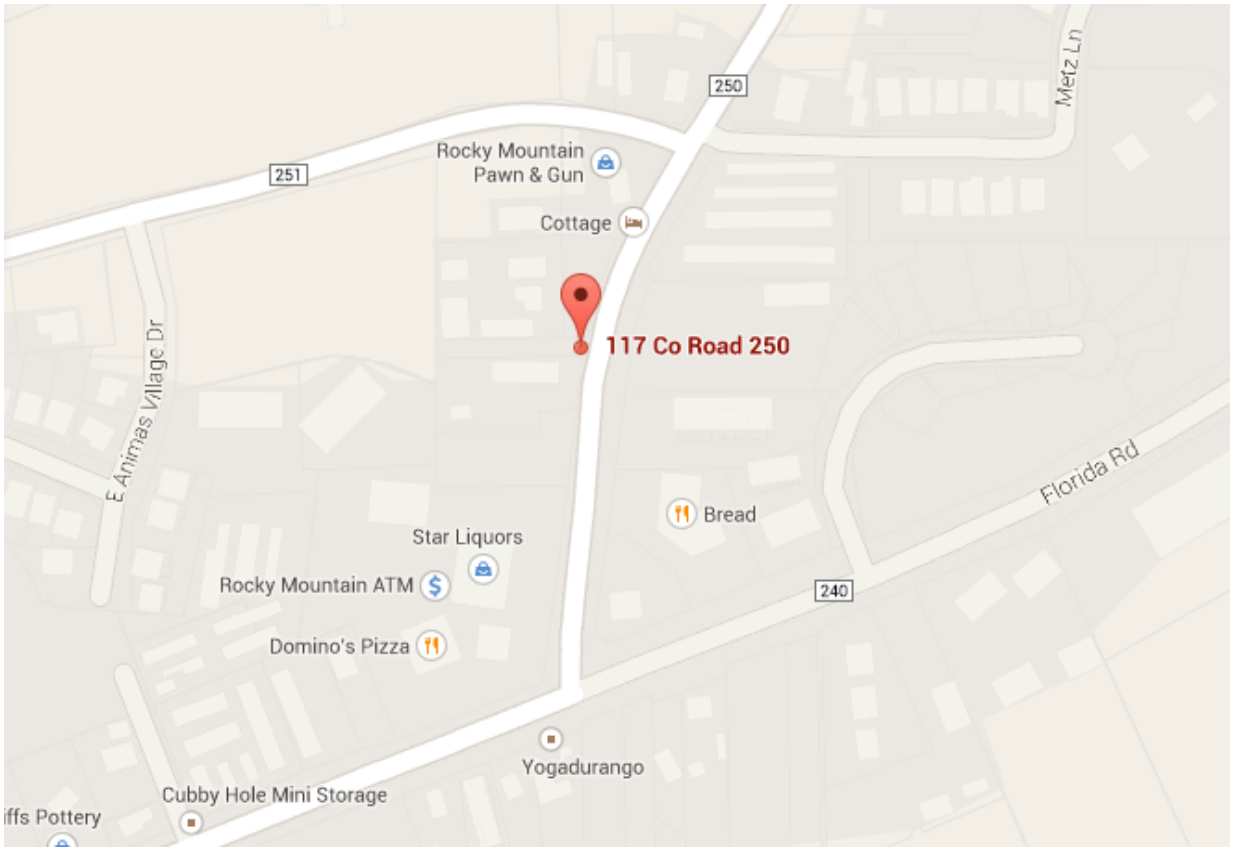
Thank you,

Durango Natural Medicine

_____ _____

Signature Date

Directions to Our Office



From Hwy 550 South via Florida Road:

1.) Turn right onto East 15th street. East 15th Street bears left and becomes Florida Road
2.) Follow Florida Road. Continue straight on Florida Road through the traffic circle
3.) Turn left at the stoplight onto County Road 250. We're on the left just past the automotive garage

From Hwy 550 South via 32nd Street:

1.) Follow Hwy 550 through Durango
2.) Turn right at 32nd Street (CR 251) and follow to the intersection of County Road 250
3.) Turn right onto County Road 250
4.) We're on the right just past the pawn shop

From Florida Road East (Bayfield, Edgemont Ranch etc.)

1.) Follow Florida Road to the stoplight at the intersection of County Road 250.
2.) Turn right onto County Road 250.
3.) We're on the left just past the automotive garage.