

Welcome to Durango Natural Medicine
Please fill out and return to DNM

Health Intake Form

Durango Natural Medicine

"Invoking the Healing Power of Nature"

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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: _____ Age: _____ Sex: M F SS #: _____

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

Home Phone: _____ Wk Phone: _____ Cell: _____

Occupation: _____ Employer: _____

Is it OK to call you at work? Yes / No

Retired: _____

Is it OK to e-mail you personal medical information? Yes / No

E-Mail Address: _____

Name of Emergency Contact: _____ Phone: _____

Name of Spouse or Partner: _____

Married _____ Separated _____ Divorced _____ Widowed _____ Single _____
Partnership _____

How did you hear about this clinic?

List the most important health concerns in order of their significance to you.

1.

2.

3.

4.

5.

How are you hoping that we can help you today?

Your Opinions About Your Health

What impact have your symptoms had on your life?

Do you have any ideas about what is causing or contributing to your condition?

What do you feel needs to happen for you to get better?

Is there any additional information about your health that you would like to add?

Are you willing to make changes in your lifestyle to address your illness (for example – quitting smoking, begin an exercise program, dietary changes, etc.)?

How much change are you willing to make at this time for improving your health?

Circle One: MINIMAL SOME COMPLETE

Are you currently receiving healthcare anywhere else? Yes / No

If yes, where and from whom?

If no, when and where did you last receive medical or health care?

Do you have any contagious diseases at this time? Yes / No

If yes, what?

Weight: _____ Weight 1 year ago: _____ Maximum Weight: _____
when? _____

Height: _____ Desired weight: _____ Date of last physical exam? _____

Personal Habits

Do you eat three meals per day? YES NO	Religious or Spiritual practice? YES NO
How many hours of sleep per night? _____	Do you enjoy your job? YES NO
Do you sleep well? YES NO	Do you take vacations? YES NO
Do you wake up feeling rested? YES NO	Do you spend time outside? YES NO
Have a supportive relationship? YES NO	Do you exercise? YES
Do you smoke? YES NO	NO How often and what type?
packs/wk? _____	
Smoke previously? YES NO	
Years? _____	Do you read? YES NO hrs/wk? _____
packs/wk? _____	
Had any major traumas? YES NO	Do you watch TV? YES NO hrs/wk? _____
Have a history of abuse? YES NO	Do you eat out often? YES NO
Physical? _____	Do you eat sugar? YES
Sexual? _____	NO
Emotional? _____	Do you eat salt? YES
	NO
Do you use Alcohol? YES NO	Do you go on diets often? YES NO
How often? _____ How much? _____	Do you use recreational drugs? YES NO
Do you drink coffee? YES NO	How often? _____
Do you drink black tea? YES NO	What types? _____
	Do you drink cola? YES NO

List the **medications** that you are currently taking, including dosage. Be sure to include things such as: Laxatives, Cortisone, Tranquilizers, Pain Reliever, Appetite suppressants, Thyroid medications, Antacids, Antibiotics, Sleeping pills and Birth Control Pills.

List all **vitamins, minerals, herbs, and homeopathic remedies** you are currently taking

Typical Daily Food Intake:

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

If you know your blood type, please tell us:

Family Health History:

***Age (if living) Health (G=good or P=poor) Age at Death (if deceased)**

<u>Fill in Chart</u>	<u>Self</u>	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Child</u>
<u>*Age</u>							
<u>*Health</u>							
<u>*Age at Death</u>							
<u>Cause of Death</u>							
<u>"X" all that are applicable:</u>							
<u>Cancer</u>							
<u>Diabetes</u>							
<u>Heart Disease</u>							
<u>High Blood Pressure</u>							
<u>Stroke</u>							
<u>Epilepsy</u>							
<u>Mental Illness</u>							
<u>Asthma</u>							
<u>Hay Fever</u>							
<u>Hives</u>							
<u>Anemia</u>							
<u>Kidney</u>							

<u>Disease</u>							
<u>Glaucoma</u>							
<u>Tuberculosis</u>							
<u>Alcoholism/ Substance Abuse</u>							
<u>Other Illnesses:</u>							

Childhood Illnesses that you have had: Scarlet fever Diphtheria
Rheumatic fever
 Mumps Measles Chicken pox German Measles

Immunizations that you have had:
 Polio Pertussis Tetanus shot Diphtheria Measles/Mumps/Rubella
 Other _____

X-Rays and Special Studies

Please list any Electrocardiograms, electroencephalograms, x-rays, CAT scans, MRIs or other studies you have had done.

Hospitalization and Surgeries

Please list any hospitalizations and/or surgeries that you have had:

Major Trauma (Emotional or Accidental)

Please describe:

Allergies

To any drugs or medications?

To any foods?

To any environmental pollens/grasses?

Other?

Endocrine System (Please circle YES- I have this now, NEVER- had, PAST- had in the past.)

Hypothyroid?	YES	Excessive thirst?	YES
NEVER PAST		NEVER PAST	
Hyperthyroid?	YES	Excessive hunger?	YES

NEVER PAST
 Hypoglycemia? YES
 NEVER PAST
 Diabetes? YES
 NEVER PAST
 Fatigue? YES
 NEVER PAST
 Heat or cold intolerance? YES
 NEVER PAST

NEVER PAST
 Poor appetite? YES
 NEVER PAST
 Unexplained weight loss? YES
 NEVER PAST
 Easy weight gain? YES
 NEVER PAST
 Seasonal depression? YES
 NEVER PAST

Immune System

Slow wound healing? YES
 NEVER PAST
 Chronic fatigue syndrome? YES
 NEVER PAST
 Chronically swollen glands? YES
 NEVER PAST

Reactions to vaccinations? YES
 NEVER PAST
 Chronic infections? YES
 NEVER PAST

Nervous System

Seizures?	YES	Paralysis?	YES
NEVER PAST		NEVER PAST	
Muscle weakness?	YES	Numbness or tingling?	YES
NEVER PAST		NEVER PAST	
Loss of memory?	YES	Easily stressed?	YES
NEVER PAST		NEVER PAST	
Vertigo?	YES	Loss of balance?	YES
NEVER PAST		NEVER PAST	
Dizziness?	YES	Lightheaded?	YES
NEVER PAST		NEVER PAST	
Trembling hands/feet?	YES	Poor concentration?	YES
NEVER PAST		NEVER PAST	
Mood swings?	YES	Slurred speech?	YES
NEVER PAST		NEVER PAST	
Tics?	YES		
NEVER PAST			

Skin

Rashes?	YES	Eczema?	YES
NEVER PAST		NEVER PAST	
Hives?	YES	Dryness?	YES
NEVER PAST		NEVER PAST	
Acne, boils?	YES	Itching?	YES
NEVER PAST		NEVER PAST	
Color changes?	YES	Perpetual hair loss?	YES
NEVER PAST		NEVER PAST	
Lumps?	YES	Night sweats?	YES
NEVER PAST		NEVER PAST	
Ulceration?	YES	Sores?	YES
NEVER PAST		NEVER PAST	
Shingles?	YES	Change in hair/nails?	YES
NEVER PAST		NEVER PAST	

Head

Headaches?	YES	Head injury?	YES
NEVER PAST		NEVER PAST	
Migraines?	YES	Jaw/TMJ problems?	YES
NEVER PAST		NEVER PAST	
Lightheadedness?	YES	Loss of balance?	YES
NEVER PAST		NEVER PAST	
Dizziness?	YES		
NEVER PAST			

Eyes

Spots in Eyes? NEVER PAST	YES	Cataracts? NEVER PAST	YES
Impaired vision? NEVER PAST	YES	Glasses/Contacts? NEVER PAST	YES
Blurriness? NEVER PAST	YES	Eyestrain? NEVER PAST	YES
Color blindness? NEVER PAST	YES	Tearing or dryness? NEVER PAST	YES
Double vision? NEVER PAST	YES	Glaucoma? NEVER PAST	YES
Eye pain? NEVER PAST	YES	Night blindness? NEVER PAST	YES
Swollen eyes? NEVER PAST	YES	Circles under Eyes? NEVER PAST	YES

Ears

Impaired hearing? NEVER PAST	YES	Ringing in ears? NEVER PAST	YES
Ear aches/Itch? NEVER PAST	YES	Excessive ear wax? NEVER PAST	YES

Nose & Sinuses

Frequent Colds?	YES	Nose Bleeds?	YES
NEVER PAST		NEVER PAST	
Stuffiness?	YES	Sinus Problems?	YES
NEVER PAST		NEVER PAST	
Post Nasal Drip?	YES	Hayfever Allergies?	YES
NEVER PAST		NEVER PAST	
Loss of Smell?	YES		
NEVER PAST			

Mouth & Throat

Frequent sore throat?	YES	Sore Tongue?	YES
NEVER PAST		NEVER PAST	
Sores in mouth?	YES	Gum problems?	YES
NEVER PAST		NEVER PAST	
Hoarseness?	YES	Dental Problems?	YES
NEVER PAST		NEVER PAST	
Difficulty Swallowing?	YES	Difficulty Speaking?	YES
NEVER PAST		NEVER PAST	
Loss of Taste?	YES	Dental Cavities?	YES
NEVER PAST		NEVER PAST	
Teeth Grinding?	YES	Jaw Clicks?	YES
NEVER PAST		NEVER PAST	
Sore Lips?	YES	Copious saliva?	YES
NEVER PAST		NEVER PAST	

Neck

Pain or Stiffness?	YES	Lumps?	YES
NEVER PAST		NEVER PAST	
Swollen glands?	YES	Goiter?	YES
NEVER PAST		NEVER PAST	

Respiratory

Cough?	YES	Sputum?	YES
NEVER PAST		NEVER PAST	
Spitting up blood?	YES	Bronchitis?	YES
NEVER PAST		NEVER PAST	
Wheezing?	YES	Pleurisy?	YES
NEVER PAST		NEVER PAST	
Difficulty breathing?	YES	Emphysema?	YES
NEVER PAST		NEVER PAST	
Pain with breathing?	YES	Pneumonia?	YES
NEVER PAST		NEVER PAST	
Shortness of breath?	YES	Asthma?	YES

NEVER PAST		NEVER PAST	
- While lying down?	YES	Positive TB test?	YES
NEVER PAST		NEVER PAST	
- At night?	YES		
NEVER PAST			

Cardiovascular

Heart Disease?	YES	Angina?	YES
NEVER PAST		NEVER PAST	
High/Low Blood Pressure?	YES	Murmurs?	YES
NEVER PAST		NEVER PAST	
Blood Clots?	YES	Fainting?	YES
NEVER PAST		NEVER PAST	
Phlebitis?	YES	Palpitations/Fluttering?	YES
NEVER PAST		NEVER PAST	
Rheumatic Fever?	YES	Chest Pain?	YES
NEVER PAST		NEVER PAST	
Swelling in ankles?	YES	Stroke/Heart Attack?	YES
NEVER PAST		NEVER PAST	

Gastrointestinal

Trouble swallowing? NEVER PAST	YES	Black Stools? NEVER PAST	YES
Jaundice? NEVER PAST	YES	Diverticulitis/losis? NEVER PAST	YES
Nausea? NEVER PAST	YES	Liver disease? NEVER PAST	YES
Vomiting? NEVER PAST	YES	Vomiting blood? NEVER PAST	YES
Heartburn / Reflux? NEVER PAST	YES	Hiatal hernia? NEVER PAST	YES
Belching or passing gas? NEVER PAST	YES	Extreme appetite? NEVER PAST	YES
Decreased appetite? NEVER PAST	YES	Tired after eating? NEVER PAST	YES
Blood in stool? NEVER PAST	YES	Mucus in Stool? NEVER PAST	YES
Diarrhea? NEVER PAST	YES	Constipation? NEVER PAST	YES
Hemorrhoids? NEVER PAST	YES	Laxative Use? NEVER PAST	YES
Bowel movement how often? <hr/> Is this a change?		Colitis? NEVER PAST	YES
Gallbladder disease? NEVER PAST	YES	Anal itching? NEVER PAST	YES
Ulcers? NEVER PAST	YES	Pain or cramps? NEVER PAST	YES
Change in thirst? NEVER PAST	YES	Stomach pain? NEVER PAST	YES

Urinary

Pain on urination? NEVER PAST	YES	Increased frequency? NEVER PAST	YES
Frequency at night? NEVER PAST	YES	Unable to hold urine? NEVER PAST	YES
Bladder Infections? NEVER PAST	YES	Kidney stones? NEVER PAST	YES
Unable to urinate? NEVER PAST	YES		

Circulation

Cold hands/feet?	YES	Varicose veins?	YES
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NEVER PAST		NEVER PAST	
Deep leg pain?	YES	Anemia?	YES
NEVER PAST		NEVER PAST	
Easy bleeding/bruising?	YES	Thrombophlebitis?	YES
NEVER PAST		NEVER PAST	

Musculoskeletal

Joint pain or stiffness?	YES	Broken bones?	YES
NEVER PAST		NEVER PAST	
Muscle spasms/cramps?	YES	Back/Neck pain?	YES
NEVER PAST		NEVER PAST	
Weakness?	YES	Arthritis?	YES
NEVER PAST		NEVER PAST	

Emotional

Depression?	YES	Tension?	YES
NEVER PAST		NEVER PAST	
Mood swings?	YES	Suicidal thoughts?	YES
NEVER PAST		NEVER PAST	
Job stress?	YES	Anxiety/nervousness?	YES
NEVER PAST		NEVER PAST	
Recent divorce or breakup?	YES	Financial stress?	YES
NEVER PAST		NEVER PAST	
Death of Someone close?	YES	Seasonal depression?	YES
NEVER PAST		NEVER PAST	
Treated for emotions?	YES		
NEVER PAST			

Menstrual History

Age at onset of menses?

How many days does your period last? _____

First day of last menstrual period:

Are your cycles regular?

YES NO

Do you bleed between cycles?

Any clotting?

YES NO

YES NO

Number of days between 1st day of one period and the 1st day of the next?

Do you have any difficulty with gyn exam?

YES NO

Date of last PAP smear?

Was it normal?

YES NO

Do you have any problems with the following:

Premenstrual tension?

YES NO

Pain?

YES NO

Heavy bleeding?

YES NO

Irregularity?

YES NO

Bleeding between periods?

YES NO

Breast pain/tenderness?

YES NO

Cramping?

YES NO

Abnormal PAPs?

YES NO

Pregnancy History

No. of pregnancies?

No. of miscarriages?

No. of tubal/ectopic pregnancies?

Any difficulty conceiving?

YES NO

No. of live births?

No. of abortions?

Any complications of pregnancy?

Birth Control History

Are you sexually active?

YES NO

Sexual Orientation?

If yes, what birth control are you currently using?

What birth controls have you used in the past (please include dates)?

Birth control pills

What kind?

YES NO
IUD
YES NO
Cervical Cap
YES NO
Sponges
YES NO
Foam
YES NO
Other?

What kind?

What kind?

Condoms
YES NO
Diaphragm
YES NO
Any problems encountered?

Any hormone medications used?

What kind?

YES NO
DES
YES NO
Steroids
YES NO
Thyroid meds
YES NO
Other:

Provera
YES NO
Estrogen
YES NO
Morning After Pill
YES NO
Cortisone
YES NO

—

Women's General History

Do you do self-breast exams? Regularly?
 YES NO YES NO

Do you have any pain with intercourse?
 YES NO

Do you have any problems with:

Endometriosis? YES NO	Cancer? YES NO
Pelvic Inflam. Disease? YES NO	Hot Flashes? YES NO
Difficulty Conceiving? YES NO	Cervical dysplasia? YES NO
Nipple discharge? YES NO	Bladder infections? YES NO
Breast lumps/tumors? YES NO	Hysterectomy? YES NO
Sexual difficulties? YES NO	Cervical abnormality? YES NO
Menopausal symptoms? YES NO	Uterine abnormality? YES NO
Uterine abnormality? YES NO	Ovarian cysts? YES NO
Sexually Trans. Disease? YES NO	Vaginal discharge? YES NO

- If yes, circle which ones:

Herpes	Venereal Warts	Gonorrhea
Chlamydia	Syphilis	Trichomonas
Vaginal Infections	Is there anything else?	

Men's Health History

Hernias? NEVER PAST	YES	Testicular Masses? NEVER PAST	YES
Penile pain? NEVER PAST	YES	Testicular pain? NEVER PAST	YES
Erectile difficulty? NEVER PAST	YES	Testicular swelling? NEVER PAST	YES
Penile discharge? NEVER PAST	YES	Prostate problems? NEVER PAST	YES
Sexually active? NEVER PAST	YES	Sexual Orientation?	
Do you use protection? NEVER PAST	YES	Premature ejaculation? NEVER PAST	YES
- If yes, what type?		Impotence?	YES

_____	NEVER PAST				
Any penile sores?	YES	NEVER PAST	History of inguinal hernia?	YES	
NEVER PAST		NEVER PAST			
Monogamous relationship?	YES	NEVER PAST			
Sexually Transmitted disease?				If yes, circle which ones?	
	YES	NO			
Chlamydia	Gonorrhea	Condyloma	Herpes	Syphilis	Venereal Warts

Hobbies & Interests

What are your main interests and hobbies?

What do you enjoy the most in life?

Thank you for completing and returning your Health Intake Form to Durango Natural Medicine. Please let us know if you have any questions regarding this form or our healthcare practice.