Northwestern Medicine®

Osher Center for Integrative Medicine

Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

Primary Care Provider (if not joining our Primary Care practice):

_____

How did you hear about us? _____

What health issues do you want to focus on during today's visit?

_____

_____

Current Medical Problems (e.g. diabetes, heart disease, hypertension, asthma):

1.	4.	7.
2.	5.	8.
3.	6.	9.

Past Medical/Surgical History Please list any **major** past surgeries, illnesses, hospitalizations (include year or date and location if known):

1.	4.	7.
2.	5.	8.
3.	6.	9.

Medications and Dietary Supplements Please list all prescribed and over-the-counter medications, supplements, vitamins or herbal products you use on a regular basis:

Medicine or Supplement including Dose	Frequency Taken
1.	
2.	
3.	
4.	
5.	
6.	

Allergies Please list any drugs that you have allergies to (including reaction):

_____ _____

_____ _____

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Family History Have your close relatives had the following?

	Father	Mother	Brother	Sister	PGF	PGM	MGF	MGM	Other
Alive (A) or Deceased (D)									
Heart attack or heart disease									
Stroke									
High blood pressure									
High Cholesterol									
Diabetes									
Thyroid disease									
Breast cancer									
Colon cancer									
Prostate cancer									
Other Cancer--what type?									
Kidney Disease									
Liver Disease									
Osteoporosis									
Asthma									
Mental Health disorder									
Substance Abuse									
Autoimmune illness (e.g. psoriasis, rheumatoid arthritis, Celiac disease, lupus)									
Other									

PGF=paternal grandfather PGM=paternal grandmother MGF=maternal grandfather MGM= maternal grandmother

Substance Use Please describe current quantity used daily/weekly. If past use, list quit date:

Alcohol: _____

Tobacco: _____

Recreational Drugs: _____

Caffeine: _____

Preventive Health Please provide the most recent date and documentation when possible:

Test	Date:	**Vaccines**	Date:
Pap smear (females)		Influenza	
Mammogram (females)		Tetanus (Td or TdaP)	
Colonoscopy		Pneumonia (both)	
Bone Density		Shingles	
Eye Exam		HPV/Gardasil	

When was the first day of your last period (females only): _____

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Healthcare Team Please list all health providers that you see. Please include physicians (e.g. gynecologist), specialists, mental health professionals and any integrative providers (e.g. chiropractor, acupuncturist, naturopath, massage therapist):

NAME	SPECIALTY	CONDITION BEING TREATED

Exercise, Nutrition and Rest

What kind of exercise do you do? _____

How many hours of sleep do you usually get each night? ____ Do you have sleep concerns? Y/N

Do you have any food allergies, sensitivities or restrictions? _____

_____

Please list everything you ate in the last 24 hours **OR** in a typical day:

Morning:
Afternoon:
Evening:
Snacks:

Do you currently or have you ever had a problem with weight or eating? _____

If yes, please describe: _____

_____

Who prepares your meals? _____

Professional Development

Current or past occupation: _____

Please designate if you are working □ full-time □ part-time □ retired □ disabled □ unemployed

Relationships

Relationship status: _____

What is your living arrangement? _____

Children (age, sex, number): _____

Are you sexually active? _____If yes, with men, women or both? _____

Do you have a history of any sexually transmitted infections or diseases? _____

What are you using to avoid pregnancy (if applicable)? _____

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Pain

Are you having any pain? _____

Where? _____

For how long? _____

What have you tried to relieve your pain? _____

Physical Environment

Do you have specific health concerns about your current home or work environment (Quality of air, water, toxin exposure etc.)?

_____

Have you had hazardous environmental or occupational exposures? If yes, please describe.

_____

Spirituality

What things or activities bring you your greatest joy and meaning? What inspires you?

_____

Do you have a religious/racial/cultural heritage that is important to you?

_____

What makes you feel connected to the larger world? Describe your spiritual or religious practices if any (e.g. meditation, prayer, time in nature, worship attendance).

_____

Mind-Body Connection

Rate the amount of stress in your life: □ None □ A Little Bit □ Moderate □ Quite a Lot □ Extreme

How well do you manage stress? □ Not at All □ A Little Bit □ Moderate □ Quite well □ Excellent

What are the main sources of stress in life? (Personal, professional, financial etc.)

_____

What are your methods of coping with the stress in your life?

_____

Trauma History

Have you ever been the victim of trauma or abuse (including sexual, emotional, physical or neglect and/or being a victim of an accident, violent crime, or a natural disaster)? _____

If yes, is this an active issue in your life that you would like to address here? _____

What are your health goals?

What are your overall goals for improving your health and your life?

_____

Is there anything else that would be helpful for us to know about you?

_____

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Review of Symptoms

Please circle if you have had any of following **current** symptoms (**within past 3 months)**

GENERAL
Fever
Sweats at night
Temperature intolerance
Excessive thirst
Fatigue
Sleep difficulties
Unplanned weight change

EYES
Pain
Redness
Vision change

EAR, NOSE, THROAT
Hearing loss
Ringing in ears
Dizziness or vertigo
Bleeding gums
Nosebleeds

BREAST
Breast Pain
Masses and or Lumps
Nipple discharge
Skin changes

CARDIOVASCULAR
Chest pain
Irregular heart beat (palpitations)
Leg swelling or edema

PULMONARY
Wheezing or shortness of breath
Chronic cough
Coughing blood

HEMATOPOIETIC
Swollen lymph glands
Excessive bleeding

PSYCHOLOGICAL
Anxiety
Depression
Memory loss
Mood swings

GASTROINTESTINAL
Diarrhea
Constipation
Indigestion/heartburn
Abdominal pain
Nausea
Blood in stool
Abdominal bloating

GENITOURINARY
Pain or burning on urination
Frequent urination
Waking to urinate more than once at night
Difficulty emptying bladder
Urinary incontinence
Decreased sexual desire
Pain with intercourse
Fertility issues

Men:
Erectile dysfunction

Women:
Heavy vaginal discharge
Heavy menstrual bleeding
Painful menstrual periods
Irregular menstrual bleeding
Hot flashes/night sweats

MUSCULOSKELETAL
Generalized or all-over pain
Joint pain
Stiffness
Joint swelling
Joint redness
Back or neck pain

SKIN
Rash
New or changing moles

NEUROLOGICAL
Abnormal gait (trouble walking) or falls
Headache (severe and/or frequent)
Seizure