Integrative Medical Institute
Of Orange County

Welcome

Patient Information

Date_____

Last Name_____ First Name_____ Cell Phone_____

Home Phone_____ Work Phone_____ E-Mail _____

Address_____

City_____ State_____ Zip Code_____

E-mail_____ Referred By_____

Gender: M F Date of Birth_____ Age_____ Social Security No._____

Circle One: Minor Single Married Divorced Widowed Spouse/Parent's Name_____

Occupation (if dependent, list parent's)_____ Employer_____

Employer Address_____ City_____ State_____ Zip_____

If patient is a student, name of school/college_____ City_____ State_____

Emergency Contact_____ Phone_____ Other Phone_____

Are you insured? ☐ YES ☐ NO **Insurance Company**_____

Name of person responsible for this account_____ Relationship to patient_____

Date of Birth_____ Driver's License # _____Is this person currently a patient in our office? ☐ YES ☐ NO

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:

Major_____

Secondary/Other_____

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Patient Medical History

Please mark any of the following conditions you have now or have experienced:

O Measles
O Mumps
O Chicken Pox
O Whooping Cough
O Scarlet Fever
O Diphtheria
O Smallpox
O Pneumonia
O Rheumatic Fever
O Heart Disease
O Arthritis
O Venereal Disease
O Anemia
O Bladder Infections
O Epilepsy
O Headaches
O Tuberculosis
O Diabetes
O Cancer
O Polio
O Glaucoma
O Hernia

O Asthma
O Hives or Eczema
O AIDS or HIV+
O Infectious Mono
O Blood or Plasma Transfusions
O High or Low Blood Pressure
O Hemorrhoids
O Bronchitis
O Stroke
O Hepatitis
O Ulcer
O Mitral Valve Prolapse
O Kidney Disease
O Thyroid Disease
O Bleeding Tendency
O Neck Pain
O Sleeping Problems
O Low Back Pain
O Nervousness
O Tension
O Irritability
O Dizziness

O Pain Between Shoulders
O Neck Stiff
O Joint Swelling
O Fever
O Loss of Balance
O Ringing in Ears
O Jaw/TMJ Problems
O Pain in Hands or Arms
O Numbness in Hands or Arms
O Pain in Legs or Feet
O Numbness in Legs or Feet
O Fatigue
O Depression
O Lights Bother Eyes
O Loss of Memory
O Shoulder Pain
O Sinus
O Shortness of Breath
O Allergies
O Cold Hands
O Cold Feet
O Chest Pains

O Painful Urination
O Stomach Upset
O Heartburn/Reflux
O Weight Loss
O Loss of Smell or Taste
O Any Other Condition
Please list_____
_____
_____

For Women Only:

□ Premenstrual tension
□ Menopausal symptoms
□ Excessive flow
□ Tubal ligation
□ Vaginal discharge
□ Unable to get pregnant
□ Menstrual cramps
□ Hysterectomy
□ Lumps in breast
□ Irregular cycle

Are you pregnant? □ YES □ NO
Date of last menstrual period _____

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital, city, state

Medications (include nonprescription)

_____

Patient Social History

Marital status: □ Single □ Married □ Seperated □ Divorced □ Widowed
Use of alcohol: □ Never □ Rarely □ Moderate □ Daily
Use of tobacco: □ Never □ Previously, but quit:_____ □ Current packs/day_____
Use of drugs: □ Never □ Type/frequency_____
Excessive exposure at home or work to: □ Fumes □ Dust □ Solvents □ Airborne particles □ Noise

Family Medical History

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

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Review of Systems

Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS
O Good general health lately
O Recent weight change
O Fever
O Fatigue
O Headaches

EYES
O Eye disease or injury
O Wear glasses/contact lenses
O Blurred or double vision

EARS/NOSE/MOUTH/THROAT
O Hearing loss or ringing
O Earaches or drainage
O Chronic sinus problems or rhinitis
O Nose bleeds
O Mouth sores
O Bleeding gums
O Bad breath or bad taste
O Sore throat or voice change
O Swollen glands in neck

CARDIOVASCULAR
O Heart trouble
O Chest pain or angina pectoris
O Palpitation
O Shortness of breath walking or lying flat
O Swelling of feet, ankles or hands

RESPIRATORY
O Chronic or frequent cough
O Spitting up blood
O Shortness of breath
O Wheezing

GASTROINTESTINAL
O Loss of appetite
O Change in bowel movements
O Nausea or vomiting
O Frequent diarrhea
O Painful bowel movements or constipation
O Rectal bleeding or blood in stool
O Abdominal pain

GENITOURINARY
O Frequent urination
O Burning or painful urination
O Blood in urine
O Change in force of strain when urinating
O Incontinence or dribbling
O Kidney stones
O Sexual difficulty
O Male – testicle pain
O Female – pain with periods
O Female – irregular periods
O Female – vaginal discharge
Female - # of pregnancies_____
Female - # of miscarriages_____
Female – date of last pap smear_____

MUSCULOSKELETAL
O Joint pain
O Joint stiffness or swelling
O Weakness of muscles or joints
O Muscle pain or cramps
O Back pain
O Cold extremities
O Difficulty in walking

INTEGUMENTARY (skin, breast)
O Rash or itching
O Change in skin color
O Change in hair or nails
O Varicose veins
O Breast pain
O Breast lump
O Breast discharge

NEUROLOGICAL
O Frequent or recurring headaches
O Light headed or dizzy
O Convulsions or seizures
O Numbness or tingling sensations
O Tremors
O Paralysis
O Head injury

PSYCHIATRIC
O Memory loss or confusion
O Nervousness
O Depression
O Insomnia

ENDOCRINE
O Glandular or hormone problem
O Excessive thirst or urination
O Heat or cold intolerance
O Skin becoming dryer
O Change in hat or glove size

HEMATOLOGIC/LYMPHATIC
O Slow to heal after cuts
O Bleeding or bruising tendency
O Anemia
O Phlebitis
O Past transfusion
O Enlarged glands

ALLERGIC/IMMUNOLOGIC
History of skin reaction or other reaction to:
O Penicillin or other antibiotics
O Morphine, Demerol, or other narcotics
O Novocain or other anesthetics
O Aspirin or other pain remedies
O Tetanus antitoxin or other serums
O Iodine, methiolate or other antiseptics
Other drugs/medications:_____
_____
_____
_____
_____
Known food allergies:_____
_____
_____
_____
Environmental allergies:_____
_____
_____
_____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

X_____ _____
Signature of patient Date

Doctor's Review:_____
_____
_____
_____

Signature of Doctor _____ Date _____