Keystone NATURAL FAMILY MEDICINE

10153 E. Hampton Ave. Suite 104
Mesa, AZ 85209
480-535-5688
www.keystonemedicine.com

Dr. Kristen Bishop
Dr. Jorge Reveron
Dr. Samantha Randahl
Dr. Robyn Wright

Date: _____

General Information

First Name: _____ Last Name: _____

Birthdate: _____ Age: _____ Sex: _____ Weight: _____ Height: _____

Occupation: _____

Marital Status (please circle): ☐ Single ☐ Married ☐ In-Relationship ☐ Divorced

Do you have any children: ☐ Yes ☐ No Ages: _____

Phone Number: _____

Personal email address: _____

How did you hear about us (please circle): Google Outdoor Sign Facebook Other_____

Please complete this questionnaire as thorough as possible. This is a confidential record and will not be released, except when you have provided us with written authorization to do so. Thank you.

HEALTH AND WELLNESS CONCERN

What are your main health concerns?

Primary Health Concerns *Please prioritize 1 or 2 health concerns that you would like to address during your first appointment.*	If applicable, list prior approaches related to your concerns:		
	Prior Diagnosis	***Prior Labs/Imaging***	***Prior Treatments***

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Please check any severe or life-threatening allergies (i.e. food, drug, or environmental allergies):

- ☐ Seasonal Allergies
- ☐ Shellfish allergy
- ☐ No Known Food Allergy
- ☐ Sulfa Allergy
- ☐ Other Allergy (specify below)
- ☐ No Known Drug Allergy

Reaction to the allergy:

_____

_____

Please list prescription and over-the-counter medications that you are currently taking, with dosages (if known):
(**Example: Tylenol 200mg – taking it two times per day; Metformin 500mg taking it once daily)**

MEDICATION *(name and strength)*	**DOSE** *(how much and how often)*

Please list any supplements, vitamins, minerals, herbs, remedies, including athletic performance supplements you are currently taking, with dosages if known: (If more than 5, please list them on a separate document)
(**Example: Vitamin C 1000mg – taking it once daily)**

SUPPLEMENT *(name and strength)*	**DOSE** *(how much and how often)*

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Please list any surgeries or hospitalizations you have had in the past. Please provide year and/or month:

1. _____ 3. _____
2. _____ 4. _____

DIET

Please describe the foods you typically eat at each meal:

- Breakfast: _____
- Lunch: _____
- Dinner: _____
- Snacks: _____
- Beverages – how many **cups or ounces** of each beverage do you consume **PER DAY**?
  - Water: _____ Soda: _____ Juice: _____
  - Coffee: _____ Tea: _____ Energy Drinks: _____

Do you have any cravings? ☐ Yes ☐ No

If so, are your cravings for: ☐Sweets/Carbs ☐Caffeine ☐Salty ☐other: _____

Do you follow any particular diet regimen or restrictions? If yes, please describe: _____

_____

How often do you eat red meat, cheese, fried foods, or high fat foods?

☐Always ☐Most days ☐Some days ☐Never

Do you eat 5-9 servings of fruits and vegetables each day? (One serving = medium apple, pear, or orange; small banana; or half-cup of a vegetable like broccoli)

☐Always ☐Most days ☐Some days ☐Never

LIFESTYLE AND HABITS

Do you exercise? ☐ Yes ☐ No If yes, how often do you exercise in a week: _____

What type of exercises do you do? _____

Do you smoke cigarettes/cigars or use nicotine gum? ☐ Yes ☐ No How much/often? _____

How much alcohol do you drink? How often? ☐ Beer ☐ Wine ☐ Hard Liquor

☐ Don't Drink ☐ 0-1 drinks per month ☐ 0-3 Drinks per week ☐ 0-3 Drinks per day

Do you use recreational drugs (including marijuana use)? ☐ Yes ☐ No How often? _____

Have you ever been treated for alcohol or drug dependence? ☐ Yes ☐ No

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How would you rate your stress level? (1=poor, 10=extreme) 1 2 3 4 5 6 7 8 9 10

How would you rate your stress handling? (1=poor, 10=extreme) 1 2 3 4 5 6 7 8 9 10

How is your energy level? (1=tired, 10=great/energetic all the time) 1 2 3 4 5 6 7 8 9 10

How is your sleep? ☐ Well ☐Trouble falling asleep ☐Trouble waking up ☐Insomnia

If having any sleeping difficulties, how long has this been happening? _____

How many hours do you sleep each night on average? _____

Do you wake up tired? ☐ Yes ☐ No Do you sleep in a completely dark room at night? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No Healthy Libido: ☐ Yes ☐ No

If Yes, currently active with: ☐one partner ☐ multiple partners

Do you and your partner use contraceptive and/or protective methods? ☐ Yes ☐ No

What type of contraceptive is used: _____

MEDICAL HISTORY

Family History

Indicate illnesses in blood relatives (i.e. Parents, Grandparents, Siblings). Check Yes to all that apply, and leave all others blank.

- ☐ Substance abuse
- ☐ Anemia
- ☐ Bleeding or clotting disorder
- ☐ Breast disease
- ☐ Cancer: _____
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Mental illness
- ☐ Depression
- ☐ Suicide
- ☐ Migraines/headaches
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Arthritis
- ☐ Lupus
- ☐ Glaucoma
- ☐ Autoimmune disorder
- ☐ Other: _____

Past Medical History

Only check those questions to which you answer yes (leave the others blank). Please comment below for those you answered YES to. ***Have you ever had or do you have any of the following health problems?***

- ☐ Bleeding tendency
- ☐ Breast disease
- ☐ Cancer: _____
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Eating disorder
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Heart murmur
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Hepatitis
- ☐ Glaucoma
- ☐ Dental disease
- ☐ Migraine headaches
- ☐ Stroke
- ☐ Seizure/Seizure disorder
- ☐ Jaundice
- ☐ Liver disease
- ☐ Gallbladder disease
- ☐ Gastritis/Ulcer disease
- ☐ Acid reflux

- ☐ Hemorrhoids
- ☐ Kidney infection
- ☐ Bladder infection
- ☐ Kidney stones
- ☐ Thyroid disorders
- ☐ Varicose veins
- ☐ Sleep apnea
- ☐ Asthma
- ☐ Chronic obstructive pulmonary disease
- ☐ Tuberculosis
- ☐ Seasonal allergies
- ☐ Environmental allergies
- ☐ Blood clots
- ☐ Serious trauma
- ☐ Sexually Transmitted Infection
- ☐ Other: _____

Symptoms

Are you currently having or have you recently had any of the following symptoms? *Check those that apply to you, leave all others blank.*

- ☐ Fevers
- ☐ Night sweats
- ☐ Unexplained weight loss/gain
- ☐ Fatigue
- ☐ Headaches
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Eye pain
- ☐ Ear pain
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Hoarse voice
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Chest pain
- ☐ Palpitations/irregular heartbeat
- ☐ Swelling of the extremities
- ☐ Shortness of breath
- ☐ Lightheadedness
- ☐ Change of appetite
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Rectal pain
- ☐ Change in bowel habits
- ☐ Blood in stool
- ☐ Black stool
- ☐ Muscle, bone, or joint pain
- ☐ Leg cramps
- ☐ Skin color changes
- ☐ Persistent bruising
- ☐ Change in size/color of mole
- ☐ Numbness in extremities
- ☐ Muscle weakness
- ☐ Tremor
- ☐ Urinary symptoms
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Incontinence/loss of urine
- ☐ Pain with urination
- ☐ Sexual dysfunction
- ☐ Mood changes
- ☐ Difficulty sleeping

Comments: _____

_____

_____

Female Reproductive

Age period began: _____ Last Menstrual Period Date: _____

Days between cycle: _____ Age menopause began: _____

# of pregnancies: _____ # of live births: _____ # of miscarriages: _____ # of abortions: _____

☐ Heavy bleeding ☐ PMS ☐ Food cravings

☐ Cramping ☐ Bloating ☐ Headaches

Last PAP Smear: _____ Any abnormal PAPs: ☐ Yes ☐ No ☐ Past

Last Mammogram: _____ Any abnormal Mammograms: ☐ Yes ☐ No ☐ Past

Any DEXA scan: _____ ☐ Yes ☐ No What were the results: _____

What types of birth control have been used and ages used: _____

Do you use hormones? ☐ Yes ☐ No ☐ Past

Pain with intercourse: ☐ Yes ☐ No Dry Vagina: ☐ Yes ☐ No

Any Sexually Transmitted Disease / illness: ☐ Yes ☐ No ☐ Past If yes, which one: _____

Male Reproductive

Testicular pain? ☐ Yes ☐ No ☐ Past Hernia? ☐ Yes ☐ No ☐ Past

Penile discharge: ☐ Yes ☐ No Erectile dysfunction: ☐ Yes ☐ No

Difficulty urinating: ☐ Yes ☐ No Increased urination frequency: ☐ Yes ☐ No

Incomplete bladder emptying: ☐ Yes ☐ No Weak urine stream: ☐ Yes ☐ No

Nighttime urination? ☐ Yes ☐ No How often per night? _____

Last digital rectal exam: _____ Last colonoscopy: _____ Last PSA: _____

Any Sexually Transmitted Disease / illness: ☐ Yes ☐ No ☐ Past If yes, which one: _____

Mental/Emotional

Depression: ☐ Yes ☐ No Anger/irritability: ☐ Yes ☐ No

Anxiety: ☐ Yes ☐ No Suicidal: ☐ Yes ☐ No

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How willing are you to make changes to improve your health? (1= not willing, 10= very willing)

1 2 3 4 5 6 7 8 9 10