Clara Barnett ND LAc

PATIENT INFORMATION

Patient Name: _____ Date of Birth_____
Today's date: _____

Address:_____
Phone:_____ . Ok to leave message? yes/no
Email:_____
Emergency contact: (name and number)_____
Person responsible for account:

Health concerns in order of priority:

Current treatments and names of practitioners:

Past Medical History: (please circle all that apply) ☐ **NONE**

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis A, B or C
High Blood pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other _____

Past Surgical History: (please circle all that apply) ☐ **NONE**

Appendix Removed
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Cyst
Ovaries: Tubal Ligation
Prostate Removed: Prostate Cancer
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

Other _____

Hospitalizations: _____

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Skin Disease History: (please circle all that apply) ☐ **NONE**

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
History of cold sores/oral herpes
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

Other _____

Do you wear Sunscreen? ☐ Yes ☐No
If yes, what SPF? _____
Do you tan in a tanning salon? ☐ Yes ☐No

Do you have a family history of Melanoma?
☐ Yes ☐ No
If yes, which relative(s)? _____

Medications: (Please enter all current medications)

Supplements: Date began/Dose/Reason

Allergies: (Please enter all allergies) ☐ Check here if you have no known drug allergies

Drug allergy:	**Drug reaction:**
Food allergy:	**Reaction:**

Social History: (Please circle all that apply)

DIET: (Please describe a typical days diet for you, including what time and where meals are consumed)

Breakfast	Lunch	Dinner	Snacks

Caffeine (cups per day):

Bowel movement: (times of day, quality)

Sources of stress and how you manage your stress:

Exercise: (type/frequency/duration)

Goal for your health and what you believe is your greatest challenge?

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Cigarette Smoking:
☐ Currently Smokes
☐ Never smoked
☐ Former Smoker

Alcohol Use:
☐ -None
☐ -Less than 1 drink per day
☐ -1-2 drinks per day
☐ -3 or more drinks per day

Other:
☐ Not sexually active
☐ Sexually active with one partner
☐ Sexually active with more than one partner
☐ Same-sex partner (same gender: female/female or male/male)
☐ Drug use
☐ IV drug use

Occupation and hours per week of work:
_____

Weight: (current and past)
Height:

Date of Last Physical Exam:
Gynecological Exam: Date of last pap smear:_____ Abnormal paes/no explain: _____
Over 50, Colonoscopy?
Visual acuity exam?
Dental exam?

Family Medical History:
Please list major illnesses/conditions of any first degree relative, including allergies, autoimmune disease, cancer, heart disease, diabetes, stroke, skin conditions, digestive disorders, osteoporosis,

ALERTS: (please circle or check all that apply)

Are you pregnant or currently trying to get pregnant? ☐ Yes ☐ No
Are you currently breastfeeding? ☐ Yes ☐ No
Require antibiotics prior to a surgical procedure ☐ Yes ☐ No

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical antibiotics
Artificial heart valve
Artificial joint replacement-
(-within 2 years)
Allergy to latex
Blood thinners
Defibrillator
HIV/AIDS
Pacemaker
Rapid heartbeat with epinephrine
MRSA

Review of Systems: Are you currently experiencing any of the following?
(Check off for yes, leave blank for no)

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Allergic/Immunologic:
- Asthma

Constitutional:
- Excessive fatigue
- Fever or chills
- Low energy
- Sleep disturbance

Endocrine:
- Weight gain/loss
- Menopause/Perimenopause
- PMS/Irregular cycles

HEENT:
- Visual changes
- Mouth
- Throat

Gastrointestinal:
- Abdominal pain
- GI upset
- Ulcer
- Acid reflux
- Loose stool
- Constipation
- Bloating
- Excessive gas
- Appetite low/high

Urinary
- Infection
- Incontinence

Hematology / Oncology/Lymphatic:
- Swollen lymph nodes
- Swelling of hands or feet

Musculoskeletal:
- Back pain
- Joint aches/arthritis
- Muscle pain
- Weakness
- Osteoporosis

Neurological:
- Headache

Psychology:
- Anxiety
- Mood

Dermatology
- Eczema
- Psoriasis
- Acne
- Rash
- Infection
- Dry Skin
- Skin cancer

Cardiovascular/Pulmonary
- Chest pain
- Palpitations
- Shortness of breath

Language:_____ Race_____Ethnic Group: _____

Preferred pharmacy Name: _____

Phone#: _____ City or Zip code: _____

Primary Care Doctor: _____
first name last name phone # Clinic name

Referring Doctor (if applicable): _____
first name last name phone # Clinic name

Thank you for your time and for filling this form out as completely as possible.