Welcome and Thank You for choosing Prescott Medical Aesthetics

PRESCOTT MEDICAL
AESTHETICS
Amber Walz, ND

Medical Intake Form

Personal Information

Patient Name: _____

Address: _____

City/State/Zip: _____

Birthdate: _____ Age: _____ Gender: M_____ F_____

Home Phone: _____ Cell Phone: _____

Email address: _____

Marital Status: M ___ S ___ W ___ D ___ Number of Children: _____

Spouse's Name: _____ Cell Phone: _____

Patient occupation: _____

In case of emergency

Contact name: _____

Contact phone number: _____ Relationship: _____

Medical History

What is your level of health? Excellent ____ Good ____ Fair ____ Poor ____

What is your primary health concern you would like to address?

_____

Past Medical History: (previous injury, illness, health concern)

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Review of Systems:
Please check next each item as it relates to your health:

Constitutional:
o Weight loss
o Fatigue
o Fever
o Night sweats
o Loss of appetite
o Significant weight loss/ gain
o Insomnia

HEENT:
o Headache
o Corrective lenses
o Eye pain
o Visual changes
o Difficulty hearing
o Ringing in the ears
o Allergies
o Sinus pain
o Congestion
o Post-nasal drip
o Sneezing
o Toothache
o Sore throat
o Pain with swallowing

Cardiovascular:
o Chest Pain
o Chest tightness
o Palpitations/ fluttering
o Faintness
o Swelling (edema) in the legs/ ankles
o Claudication/ calf pain
o Poor circulation

Respiratory:
o Asthma
o Shortness of breath
o Coughing
o Wheezing
o Difficulty breathing
o Exercise intolerance

Abdominal:
o Abdominal pain
o Difficulty swallowing
o Hiccups
o Indigestion
o Heartburn/ reflux
o Bloating
o Cramping
o Food avoidance
o Nausea/ Vomiting
o Constipation/ Diarrhea
o Black or bloody stool

Genitourinary:
o Discharge
o Pain
o STD
o Yeast/ BV infection
o Urinary incontinence
o Frequency
o Urgency
o Hesitancy
o Pain with urination
o Night urination
o Excessive urination
o Blood in the urine

Musculoskeletal:
o Arthritis
o Muscle pain
o Joint pain/ stiffness (> waking/ movement)
o Joint swelling
o Decrease range of motion

Integumentary/ Breast:
o Eczema/ Psoriasis
o Itching
o Rashes/ lesions
o Lumps/ bumps/ masses
o Discoloration
o Skin tags
o Breast pain/ soreness
o Breast lumps/ discharge

Endocrine:
o Hot/ cold intolerance
o Hair loss
o Change in appetite
o Mood swings
o Dry skin
o Hypoglycemia
o Excessive sweating
o Excessive thirst
o Low blood pressure
o Menstrual irregularities
o Low libido
o Hot flushes/ flashes
o Difficulty with erection

Neurological:
o Headache/ migraine
o Change in senses
o Dizziness/ Vertigo
o Hx seizures
o Tremors
o Numbness/ tingling
o Limb weakness
o Poor balance
o Poor coordination
o Poor speech
o Poor memory/ word recall
o Cognitive changes

Psychological:
o Depression
o Anxiety
o Difficulty concentrating
o Paranoia
o Episodic personality change

Hematology/ Lymph:
o Easy bruising/ bleeding
o Swollen/ tender lymph nodes

Females Only:
Date of last mammogram: _____
Normal ___ Abnormal ___
Date of last PAP: _____
Normal ___ Abnormal ___
Age of onset periods: _____
Age of onset menopause: _____
Periods regular? Y__ N___
Number of pregnancies ____

Family History:

Condition: _____ Relationship: _____ Age of onset: ____

Condition: _____ Relationship: _____ Age of onset: ____

Condition: _____ Relationship: _____ Age of onset: ____

Condition: _____ Relationship: _____ Age of onset: ____

Condition: _____ Relationship: _____ Age of onset: ____

Medications & Supplements:

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Name: _____ Brand: _____ Dose: _____

Primary Care Provider: _____ Phone: _____

I clearly understand & agree that all services rendered to me are charged directly to me & that I am personally responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for treatment rendered to me will become immediately due and payable. All services are non-refundable.

Patient signature: _____**Date:** _____

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