Dear Prospective Patient,

Welcome to my integrative consulting practice!

Enclosed are patient intake forms. Before your scheduled appointment, please complete them as thoroughly as you possibly can.

Your consultation visit will consist of assessment of your medical history, a modified physical examination and recommendations, with discussion. This is scheduled for 1 1/2 hours.

Please bring with you photo copies of any recent lab work (for me to keep), as well as a list of all supplements or medications you are currently taking, including dosages.

When you arrive with completed forms and where appropriate, lab copies and a list of medications and supplements, it maximizes the information I need in order to best assist you and the time we can spend together in discussion.

If you are not able to keep your scheduled appointment for any reason, please call the Integrative Medicine Center at 607-275-9697 so that your visit can be rescheduled to a more convenient time. We greatly appreciate a 24-hour notice for cancellation wherever possible so that your slot may be used by someone waiting for a sooner appointment.

I look forward to meeting you and supporting you in developing goals and recommendations for your best possible health.

Yours,

Nancy B. Stewart, M.D.
Board-Certified in Family Medicine
Graduate, Fellowship in Integrative Medicine, University of Arizona

Patient Intake Form
Nancy B. Stewart, M.D.
Integrative Medicine Center

Name:

Reason(s) for consultation:

What are your goals for this visit?

Name of current/last position:

Major current health issues/conditions:

Past medical history/medical conditions:

Operations you have had, and approximate year(s)

Allergies and reactions to medications:

Other allergies, and tolerances and reactions:

Please list all medications, supplements, herbs and medicinal foods you are currently taking:

Year of last tetanus booster:_____

Year of last cholesterol test:_____

If you are over 50, year of last colonoscopy:_____

Women: Please list the following: Last menstrual period or age at menopause_____

Pregnancies_____ # Births_____ Approximate date of last Pap smear:_____

Family health history (please list all major medical conditions known in your family members):

Mother:

Father:

Sisters (how many?_____):

Brothers (how many?_____):

Grandparents:

Other:

Have any of your relatives had the following illnesses, and if so, who?

breast cancer_____ colon polyps or cancer_____diabetes_____
osteoporosis_____hypertension_____
heart attack before 65 in women or 55 in men_____

Occupation:

Education (how far you went in school, degrees):

Hobbies/other recreational interests:

Do you smoke cigarettes or use tobacco?____ How many packs per day?____
For how many years?____

If you have quit using tobacco, when did you quit?_____ How many years did you smoke?____
How many packs per day?____

Do you drink alcohol, including beer or wine?____ How many drinks per week (= 1 oz liquor,
4 oz wine, 1 beer)?____

Do you drink caffeine?____ Is so, what kind of beverage, and how many cups per day?_____

Other drugs, past and present (how often, what substances):

Please describe what you typically eat and drink for the following meals:

Breakfast:

Lunch:

Dinner:

Snacks (and when you usually eat them):

How would you describe your relationship with food:

What physical activities do you participate in (how often, how many minutes at a time)?

What are the major stresses in your life?

What do you do to relax; what do you love to do?

How much sleep you get, and does it feel like enough? Any trouble sleeping (please elaborate)?

Who do you currently live with?

Do you feel safe in all your current relationships (family, at work)?____ If not, please elaborate:

Spiritual or religious practice, present and past:

What is your general attitude toward life?

What or who are your sources of hope and strength?

Review of Systems: Please place a check in front of any problems you are **currently** having or wish to discuss.

- ○ Fever, chills
- ○ Night sweats
- ○ Hair loss
- ○ Unintended weight loss
- ○ Loss of appetite
- ○ Unusual headaches
- ○ Fainting or blackouts
- ○ Numbness or tingling
- ○ Loss of memory
- ○ Chronic fatigue or weakness
- ○ Trouble sleeping
- ○ Wide mood swings
- ○ Crying or depression
- ○ Anxiety or nervousness
- ○ Ringing ears
- ○ Dizzy spells
- ○ Hearing loss
- ○ Visual change
- ○ Eyes itching or draining
- ○ Persistent nasal congestion/drip
- ○ Excessive sneezing
- ○ Excessive snoring
- ○ Chest pains with exercise
- ○ Other chest pain or tightness
- ○ Palpitations or irregular heart
- ○ Cough
- ○ Wheezing
- ○ Shortness of breath
- ○ Coughing up blood
- ○ Frequent heartburn
- ○ Trouble swallowing
- ○ Abdominal pain
- ○ Persistent nausea or vomiting
- ○ Frequent diarrhea
- ○ Frequent constipation
- ○ Blood in stools
- ○ Frequent urination
- ○ Slow urinary stream
- ○ Painful urination
- ○ Excessive urination at night
- ○ Urinary leakage
- ○ Blood in urine
- ○ Neck or back pain
- ○ Joint pains
- ○ Leg pain when walking
- ○ Leg or ankle swelling
- ○ Rash
- ○ Nonhealing sore
- ○ Changing or bleeding mole
- ○ Unexpected lump

WOMEN

- ○ Spotting/irregular menses
- ○ Heavy menses
- ○ Unusual vaginal discharge
- ○ Brest pain or lump

MEN

- ○ Difficulty with erection
- ○ Discharge form penis
- ○ Pain or lump in testicle

HAVE YOU EVER HAD

- ○ Cancer
- ○ Abnormal pap smear
- ○ Kidney stones
- ○ Positive tuberculin test (PPD)
- ○ Clots in legs or lungs
- ○ Depression
- ○ Positive HIV test
- ○ Hepatitis
- ○ Blood transfusion
- ○ Seizure
- ○ Ulcer or stomach bleeding
- ○ Asthma
- ○ Exposure to radiation
- ○ Needle drug use
- ○ Sexual transmitted disease

Insurance Information
(Please attach Insurance cards & please print)

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ female: ___ male: ____

Date of birth: ___/___/___ Soc. Sec #: _____

Primary Ins Co: _____ policy #:_____

Insured Name: _____ Group #: _____

Insured Address: _____

Insured DOB: ___/___/___ Insured Soc. Sec_____

Patient's relationship to insured: _____

Secondary Ins Co: _____Insured name: _____

Insured address: _____DOB: ___/___/___

Group #:_____ Policy #: _____

Patient's relationship to insured: _____ Insured Soc. Sec: _____

Expired Insurance name: _____ Exp. date: _____

Patient's Employer: _____ Job title: _____

Spouse's Name: _____ Spouse's Employer: _____

Who is financially responsible for the bill: _____

It is the Patients responsibility to request a referral from your doctor to obtain
Pre-authorization for a medical encounter, if you insurance company requires it.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I have read the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above

I have been offered a copy of the privacy policy.

_____ Date: _____
(Signature requested to release Information Company for billing purposes only)