SONORAN UNIVERSITY OF HEALTH SCIENCES | Clinical Care

GENERAL PATIENT INTAKE

Date: ___________________

Preferred name:	
Legal name, *if different:*	
Preferred pronouns:	
Date of birth:	
Gender identity:	
Sex assigned at birth:	

CONCERNS

Most important concerns that you would like to address (maximum of 3):

Additional concerns:

BIOLOGICAL FAMILY MEDICAL HISTORY

Biological grandparents:

	Age	Living	Deceased	Unknown
Grandmother #1		☐	☐	☐
Grandfather #1		☐	☐	☐
Grandmother #2		☐	☐	☐
Grandfather #2		☐	☐	☐

Biological parents:

	Age	Living	Deceased	Unknown
Mother		☐	☐	☐
Father		☐	☐	☐

Biological siblings:

	Age	Living	Deceased	Unknown
Sibling #1		☐	☐	☐
Sibling #2		☐	☐	☐
Sibling #3		☐	☐	☐
Sibling #4		☐	☐	☐
Sibling #5		☐	☐	☐

Have any of the biological relatives above ever received any of the following diagnoses?
☐ Yes ☐ No If YES, please indicate which relative(s).

☐ Allergies:	☐ Heart disease:
☐ Autoimmune disease:	☐ Genetic disease:
☐ Blood disorder:	☐ Mental illness or addictions:
☐ Cancer:	☐ Obesity:
☐ Dementia:	☐ Stroke:
☐ Diabetes:	☐ Other:

MEDICAL HISTORY

Do you have a Primary Care Physician? ☐ Yes ☐ No
If yes, please provide the following, if known:

Name:	
Address:	
Phone:	
Fax:	

Please indicate physicians or practitioners who have been involved in your care in the last three years.

List all significant prior illnesses, diagnoses, injuries, surgeries and hospitalizations, including date(s) of onset:

For example: Hypertension, March 2019

Date of last physical exam? _______________

Date of last blood work? _________________

Medical Imaging

X-ray, MRI/CTT or ultrasound: Provide type of imaging, area(s) of body, date(s), and reason.

For example: Ultrasound of pelvis, March 2019, pregnancy

Vaccination History
Have you ever had the **Disease (D), been Immunized (I), Neither (N) or Unknown (U)?**

PEDIATRIC VACCINATIONS

	D	I	N	U	Date
Diptheria & Whooping Cough (Pertussis)	☐	☐	☐	☐	
Hemophilus (HiB)	☐	☐	☐	☐	
Tetanus	☐	☐	☐	☐	
Measles	☐	☐	☐	☐	
Mumps	☐	☐	☐	☐	
German Measles (Rubella)	☐	☐	☐	☐	
Chicken Pox	☐	☐	☐	☐	
Polio	☐	☐	☐	☐	
Meningococcal	☐	☐	☐	☐	

ADDITIONAL VACCINATIONS

	D	I	N	U	Date
COVID	☐	☐	☐	☐	
Hepatitis A	☐	☐	☐	☐	
Hepatitis B	☐	☐	☐	☐	
Influenza	☐	☐	☐	☐	
Human Papilloma Virus (HPV)	☐	☐	☐	☐	
Pneumococcal Conjugated Vaccine (PCV)	☐	☐	☐	☐	
Pneumonia	☐	☐	☐	☐	
Shingles	☐	☐	☐	☐	

Have you had any adverse reactions to any vaccination? ☐ Yes ☐ No
If Yes, which vaccination(s)?

Medications / Supplements
Please include ALL current prescriptions, over-the-counter drugs, vitamins, herbs, etc. including daily dose, approximate starting date and reason for use.

For example: Magnesium bisglycinate, 200mg, March 2019, sleep aide

Allergies
Do you have any allergies? ☐ Yes ☐ No known or suspected allergies
If Yes, please check all that apply.

☐ Medication: ____
☐ Foods: ____
☐ Environmental: ____
☐ Other: ____

SOCIAL HISTORY

Please indicate your average daytime level of energy using the scale 1-10 (1 is the least and 10 is the most): ______

Are you regularly exercising? ☐ Yes ☐ No

If Yes, indicate type of exercise, how many days per week, and for how long

For example: StairMaster, 3x/week, 30 minutes

Sleep

How many hours of sleep do you usually get each night? __________

Do you wake feeling refreshed?	☐ Always	☐ Usually	☐ Rarely	☐ Never
Do you have difficulty sleeping?	☐ Yes	☐ No		
Do you wake due to pain?	☐ Yes	☐ No		
Do you wake for other reasons?	☐ Yes	☐ No		

Recreational Substance Use

Do you consume alcohol?	☐ Daily	☐ Weekly	☐ Monthly	☐ No	☐ In the past
Do you use tobacco?	☐ Daily	☐ Weekly	☐ Monthly	☐ No	☐ In the past
Do you use cannabis?	☐ Daily	☐ Weekly	☐ Monthly	☐ No	☐ In the past
Do you use recreational drugs?	☐ Daily	☐ Weekly	☐ Monthly	☐ No	☐ In the past

Have you ever been told you have an addiction or been treated for an addiction?

☐ Yes ☐ No

Diet

Do you follow a specific diet (e.g., South Beach, Paleo, Vegan, Blood-type, etc.)?

☐ Yes ☐ No If yes, what type?

How many ounces/ml of water do you drink each day? ______________________________

What types and amount of caffeine do you consume daily? __________________________

Major stressors in the last 12 months?
- ☐ Children
- ☐ Finances
- ☐ Grief/Loss
- ☐ Health
- ☐ Home life
- ☐ Relationships
- ☐ Work/employment
- ☐ Other: ______________________________________

Have you experienced abuse? ☐ Yes ☐ No
If Yes, please check all that apply.
- ☐ Emotional
- ☐ Mental
- ☐ Physical
- ☐ Sexual
- ☐ Financial

Menstrual Cycle
First day of last menses? __________________

Length of menstrual bleeding? __________________

Length of time between menstrual bleeding? __________________

Menopause
Age at menopause (=12 months after last menses): ___________________________

Surgically induced? ☐ Yes ☐ No

Check all symptoms you **currently** experience:

☐ brain fog or decreased memory	☐ night sweats
☐ decreased libido	☐ palpitations
☐ hot flashes	☐ sleep disruption
☐ incontinence	☐ vaginal dryness
☐ joint pain	☐ other
☐ mood changes	

Breast Health
Do you experience any of the following?
- ☐ breast pain
- ☐ nipple discharge
- ☐ breast lumps/masses

Biological family history of breast disease? ☐ Yes ☐ No

Date of last mammogram and results: ___________________

Gynecology and PAP Test History
Date of last PAP test and results: ____

Have you ever received an irregular PAP test result? ☐ Yes, date: _________ ☐ No

Have you experienced:

☐ ectopic pregnancy	☐ ovarian/uterine disease
☐ endometriosis	☐ pelvic inflammatory disease
☐ fibroids	☐ other: ___________________________________
☐ ovarian cysts	

Have you had any gynecological surgeries or procedures? ☐ Yes ☐ No
If Yes, indicate date and type: ____

Do you currently experience:

☐ bleeding after sexual activity	☐ pelvic pain
☐ change in vaginal odor	☐ unusual vaginal discharge
☐ genital rashes or skin changes	☐ vaginal itching
☐ pain with vaginal intercourse	☐ other: ___________________________________

Pregnancy History
Difficulty conceiving? ☐ Yes ☐ No

Number of pregnancies:	
Number of live births:	
Number of miscarriages:	
Number of abortions:	

Complications during pregnancy? ☐ Yes ☐ No
If Yes, please describe:

Prostate Symptoms:

☐ difficulty initiating urination	☐ prostate cancer
☐ dribbling of urine	☐ prostatitis
☐ enlarged prostate	☐ urination at night

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☐ incomplete urination	☐ other: ______________________________

Date of your last prostate exam (digital rectal exam): _________________________________

Check all symptoms that you currently experience:

☐ decreased libido	☐ prostate disease
☐ erectile dysfunction	☐ testicular pain
☐ genital/rectal rashes or skin changes	☐ testicular swelling
☐ hernia	☐ other: _________________________________
☐ penial discharge	

Sexual History (all genders)

Are you sexually active? ☐ Yes ☐ No

Have you experienced any of the following?

☐ bleeding after intercourse	☐ low libido
☐ difficulty achieving ejaculation	☐ pain during intercourse
☐ difficulty achieving/maintaining erection	☐ sperm abnormalities
☐ difficulty achieving orgasm	☐ other ______________________________

Have you ever received an STI (sexually transmitted infection) diagnosis? ☐ Yes ☐ No
If yes, indicate type: ____

Do you use contraceptives? ☐ Yes; please indicate type_________________________ ☐ No

Please indicate current or past use of any reproductive hormones (e.g., testosterone, progesterone, estrogen, etc.):

SIGNATURE: Patient or legally authorized individual	DATE:
PRINT NAME: Patient or legally authorized individual	RELATIONSHIP: (self, parent, legal guardian, personal representative, etc.)