New Patient Form

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THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY. IF YOU ARE UNCOMFORTABLE ANSWERING ANY QUESTIONS YOU MAY LEAVE THEM BLANK AND DISCUSS THEM WITH DR. MULYUKOVA

PATIENT INFORMATION

Name:	Date of Birth:	Gender:

How did you find Dr. Mulyukova?

❑ Insurance Referral ❑ Physician Referral ❑ Patient Referral ❑ Website ❑ Other

Referring person or website:

_____

_____

_____

*What are your **main health concerns**, in order of importance to **you**?*

_____

_____

_____

On a scale of 1 to 10, how healthy do you think you are right now?	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
How committed are you to finding the causes of your illness?	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
How committed are you to making a change?	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

What do you do regularly to support or improve your health?

_____

_____

_____

What do you do regularly that you know is bad for your health?

_____

_____

_____

What challenges, if any, do you face when implementing healthier choices for yourself?

_____

_____

_____

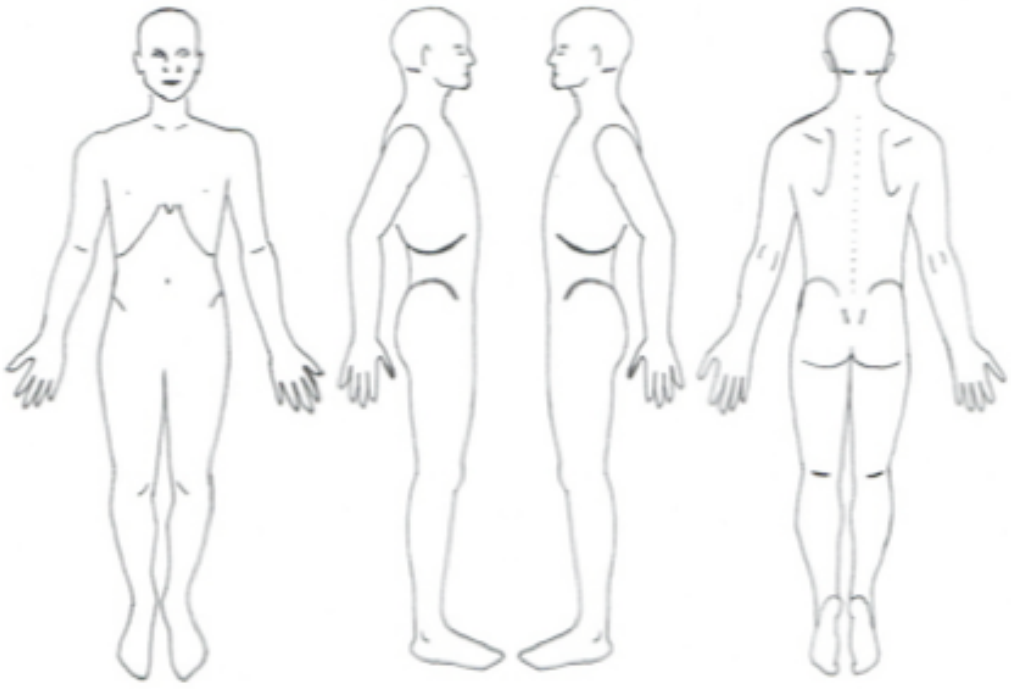
Patient Name:	Date of Birth:

MEDICATIONS/SUPPLEMENTS

Medications that you take	Supplements/Herbs/Vitamins that you take
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

Use the following illustration to indicate painful or distressed areas:
Are you experiencing pain/discomfort in any area of your body? **Y / N**
If yes, using the models to the right, please indicate the location of the discomfort by using the symbol that best describes the feeling:
X X X – Sharp and stabbing
P P P – Pins and needles
D D D – Dull and achy
N N N – Numb

PLEASE MARK ALL AREAS OF PAIN OR DISCOMFORT



Patient Name:	Date of Birth:

SOCIAL AND LIFESTYLE

Habits	Yes	No	Details	Notes
Current tobacco use	❑	❑	Packs per day:	
Past tobacco use	❑	❑	Packs per day:	When did you quit?
Alcohol consumption Types:	❑	❑	Per day? Per week?	
Recreational drug use	❑	❑	Types:	
Ever been treated for drug/alcohol abuse?	❑	❑	When?	
Seat belt use	❑	❑		
Caffeine use (circle all) Coffee, tea, soda, energy drinks	❑	❑	Cups per day?	
Regular exercise?	❑	❑	How much?	What type?
Social				
Happy with your relationship?	❑	❑	Length?	
What is your predominant emotion?				
Have you ever been emotionally or physically abused?			❑ No	❑ Yes
Do you have concerns about abuse/violence in your life right now?			❑ No	❑ Yes
Lifestyle				
Do you enjoy your work?	❑	❑		
Stress level: ❑ Low ❑ Medium ❑ High Stress source: ❑ Money ❑ Job ❑ Family/Relationship ❑ Other: What do you do to relieve stress?				
Sleep				
Problems falling asleep?	❑	❑		
Problems staying asleep?	❑	❑		
Do you wake up refreshed?	❑	❑		
How many hours of sleep do you normally get per night?				
Diet				
What is your typical breakfast?				
Typical lunch?				
Typical dinner?				
Snacks?				
How much water do you drink per day?				
How much water do you drink?				

Patient Name:	Date of Birth:

FEMALE HEALTH INFORMATION

Menstrual History			**Obstetric History**		
Age at first period:			Have you ever been pregnant?	❑ No	❑ Yes
Date of last menstrual period:			Age at first pregnancy:		
Periods regular?	❑ No	❑Yes	Number of pregnancies:		
Days between periods:			Number of living children:		
Length of flow:			Number of stillbirths:		
Heaviness of flow:			Number of miscarriages: When in pregnancy?		
Clots?	❑ No	❑ Yes	Number of tubal pregnancies:		
Pain with ovulation?	❑ No	❑ Yes	Number of abortions: When in pregnancy?		
Cramps with menses?	❑ No	❑ Yes	Number of C-sections:		
Menopause?	❑ No	❑ Yes	Date of last pregnancy:		
			Difficulty conceiving?	❑ No	❑ Yes
PMS Symptoms	❑ None		Difficulty during pregnancy?	❑ No	❑ Yes
❑ Breast tenderness	❑ Acne	❑ Mood swings	Difficulty with labor or delivery?	❑ No	❑ Yes
❑ Bloating/swelling	❑ Fatigue	❑ Headache	Difficulty with breast feeding?	❑ No	❑ Yes
❑ Other:			Future family plans?	❑ No	❑ Yes

MALE HEALTH INFORMATION

Condition	**Never**	**Past**	**Current**	**Notes**
Difficult urination	❑	❑	❑	
Testicular pain/Swelling	❑	❑	❑	
Impotence/Sexual difficulties	❑	❑	❑	
Prostate problems	❑	❑	❑	
Other:	❑	❑	❑	

SEXUAL HEALTH INFORMATION

Are you currently sexually active?	❑ No	❑ Yes	With:	❑ Men	❑ Women ❑ Both
Have you been sexually active with:	❑ Men	❑ Women	❑ Both	❑ Neither	
❑ Current ❑ Past	❑ Bisexual Men	❑ Bisexual women	❑ Prostitutes	❑ IV drug users	
Are you satisfied with your sex life?	❑ No	❑ Yes	Do you practice safer sex? ❑ No ❑ Yes		
Do you have need for birth control?	❑ No	❑ Yes			
Method of birth control currently used:			Number of sexual partners this year:		
STDs: ❑ HIV ❑ Herpes ❑ HPV/Warts ❑ Gonorrhea ❑ Chlamydia ❑ Syphilis ❑ Hepatitis					

Patient Name:	Date of Birth:

REVIEW OF SYSTEMS (Please check if you have had problems with the following)

Now	Past	Condition	Notes
		1. General	
❑	❑	Weight loss/gain (circle)	
❑	❑	Poor memory/Brain fog	
❑	❑	Fatigue	Energy level (1 – 10)?
❑	❑	Decreased libido	
❑	❑	Too hot/cold (circle)	
❑	❑	Excessive sweating/Night sweats	
❑	❑	Frequent colds/flus	
		2. Skin	
❑	❑	Dryness	
❑	❑	Rashes/Itching/Eczema	
❑	❑	Hair or nail changes	
❑	❑	Easy bruising	
❑	❑	Acne	
		3. Head/Neck	
❑	❑	Headache/Migraines	
❑	❑	Ringing in ears	
❑	❑	Poor hearing	
❑	❑	Earaches	
❑	❑	Tooth/Gum problems	Number of mercury fillings?
❑	❑	Hoarseness	
❑	❑	Sore throat	
❑	❑	Poor vision	When was your last eye exam?
❑	❑	Light sensitivity	
❑	❑	Blurred/Double vision	
❑	❑	Dry eyes	
❑	❑	Poor night vision	
		4. Lungs	
❑	❑	Difficulty breathing	
❑	❑	Persistent cough	
❑	❑	Wheezing	
		5. Cardiovascular	
❑	❑	Heart palpitations	
❑	❑	Chest pain	
❑	❑	Irregular heartbeat	

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Now	Past	Condition	Notes
❑	❑	Swelling in hands or feet	
		6. Gastrointestinal	
❑	❑	Loss of/Excessive appetite (circle)	
❑	❑	Nausea/Vomiting	
❑	❑	Abdominal pain	
❑	❑	Difficulty swallowing	
❑	❑	Indigestion/Reflux	
❑	❑	Gas/Bloating	
❑	❑	Constipation	
❑	❑	Diarrhea	
❑	❑	Blood/Mucus in stool	
		7. Genitourinary	
❑	❑	Pain with urination	
❑	❑	Urgency/Frequency	
❑	❑	Bladder incontinence	
❑	❑	Excessive thirst	
		8. Musculoskeletal	
❑	❑	Muscle pain	Where?
❑	❑	Joint pain	Where?
		9. Neurological	
❑	❑	Dizziness/Vertigo/Fainting	
❑	❑	Problems with speech/coordination	
❑	❑	Paralysis/Numbness	
		10. Psychological	
❑	❑	Anxiety	
❑	❑	Mood changes	

HEALTH HISTORY

Allergies or reactions to: ❑ Iodine ❑ Penicillin/antibiotics ❑ Sulfa drugs ❑ Nuts ❑ Scents ❑ Aspirin ❑ Local anesthetics ❑ Other:
Environmental Allergies:
History of serious illnesses, accidents, hospitalizations, or operations (what and when):

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FAMILY HISTORY

Mother:	❑ Living ❑ Deceased	Cause:		Age:
Father:	❑ Living ❑ Deceased	Cause:		Age:
Siblings:	Number living:	Number deceased:	Causes/Ages:	
Children	Number living:	Number deceased:	Causes/Ages:	

Has any family member (or you) been diagnosed with:	**Yes**	**Who? At what age?**	**Notes**
Asthma	❑		
Emphysema	❑		
Severe allergies	❑		
Thyroid problems	❑		
Stroke	❑		
Heart disease	❑		
Heart attack	❑		
Blood clots in lungs or legs	❑		
High blood pressure	❑		
High cholesterol	❑		
Ulcers	❑		
Kidney disease	❑		
Gallbladder disease	❑		
Osteoporosis	❑		
Liver disease	❑		
Colitis/Crohn's/Celiac	❑		
HIV/AIDs	❑		
Anemia	❑		
Blood disorder	❑		What kind?
Diabetes	❑		
Drinking or drug problems	❑		
Eating disorders	❑		
Cancer	❑		What kind?
Mental illness/depression	❑		
Alzheimer's disease	❑		
Other:	❑		

AND LAST OF ALL

Is there anything else I should know?

Thank you for taking the time to fill out this questionnaire. I look forward to working with you.