MOUNTAIN VIEW NATURAL MEDICINE

Lorilee Schoenbeck, ND | Adriane Morrison-Taylor, ND | Lori Clarke, ND
Michael Gravett, ND | Nina Meledandri, ND, MSOM, Lac

ANNUAL ADULT Preventative Visit

Name:_____ Date of Birth:_____

Have you moved, changed phone numbers, email address, or health insurance? Yes / No
If yes, please specify:

_____

_____

Please list any medications and supplements you are currently taking, along with doses.

Medications:	Reason:	Dose	Date began

Supplements:	Reason:	Dose	Date began

Do you need a medication refill today? Yes / No _____
Preferred Pharmacy is _____

Diet: Have you had any major dietary changes in the past year? (Ketogenic, Vegan, Weight Watchers…)

Mental Health: In the **last 2 weeks**, how often have you been bothered by the following problems?

Little interest or pleasure in doing things?

0 - Not at all 1 - Several days 2- More than half the days 3- Nearly daily

Feeling down, depressed or hopeless?

0 - Not at all 1 - Several days 2- More than half the days 3- Nearly daily

Current Health Concerns (ROS). Please check **NORMAL** or **ABNORMAL** and briefly explain.

N	**ABN**	
__	__	Constitutional (Energy, weight, body temperature, sleep, general sense of well-being) _____
__	__	Head: (headaches, vertigo, injuries…) _____
__	__	Vision/eye problems _____
__	__	Ear/nose/throat/mouth (allergies, infections etc.) _____
__	__	Cardiovascular (high BP, cholesterol...) _____
__	__	Respiratory_____
__	__	Digestive tract issues (change in bowel habits, hemorrhoids, bloating, pain…) _____
__	__	Musculoskeletal concerns (arthritis, joint problems, osteoporosis, muscle pain, weakness) _____ _____
__	__	Skin (eczema, infections, rashes, etc.) _____
__	__	Psychological (mood changes, sadness, irritability, anxiety…) _____
__	__	Neurological (numbness, tingling, balance problems, memory...) _____
__	__	Hormonal issues (diabetes, thyroid problems, menopausal, adrenal…) _____
__	__	Blood or lymph issues (current anemia, swollen glands…) _____
__	__	Allergies _____
__	__	Urinary (pain, incontinence, trouble starting urination):_____
__	__	Other _____

Please note: There may be an additional charge from your insurance provider if your concerns are not considered part of your routine preventative.

Recent Sexual History

Are you currently sexually active? _____ Partner(s) is/are (male, female, trans…) _____
What is your sexual orientation? _____
Any problems related to sexual function/libido? _____
Do you have a history of sexually transmitted disease? _____ Genital warts? _____

Recent Gynecologic History

Periods generally last _____ days and occur every _____ days.
Date of last period _____ Bleeding is… Heavy _____ Moderate_____ Light _____?
Do you experience PMS symptoms? _____
Type of birth control: _____ Are you happy with this method? _____
Are you currently experiencing any gynecological symptoms or problems? _____
Number of pregnancies? _____ Births? _____ Abortions? _____ Miscarriages? _____
Date of last Pap smear: _____ Abnormal Pap History? _____
Do you perform regular breast self exams? _____ Date of last mammogram, if any: _____
If menopausal or perimenopausal, list symptoms and concerns: _____

Lifestyle

Relationship status? single_____married_____civil union_____other_____

Any job/career changes? _____

How accessible/affordable is healthy food? _____

Highest level of education?_____

Do you feel safe in your home/neighborhood? _____

What are your primary sources of stress? And how does this stress impact your life?

_____

Do you feel that you have a support system in place? (family, friends, health professionals) _____

How many hours do you work per week? _____ Number of play/relaxation hours? _____

What do you do in order to manage stress and take care of yourself? _____

_____

What is your exercise routine? _____

Do you wear a seatbelt? Yes / No a bike helmet? Yes / N0

Caffeine/Amount? _____Alcohol/Amount? _____

Smoking history and amount? _____ Recreational drugs? _____

Are there any questions you wish answered today if there is time?