Integrative Medicine of Pueblo
200 W B St Ste 110
Pueblo, CO - 81003

Medical Intake

First Name: *

Last Name: *

DOB: *

Are you currently under the care of a primary care physician (PCP)? ☐ Yes ☐ No

If yes, what is their contact information?

Are you up to date on your annual physical exam and recommended cancer screenings? ☐ Yes ☐ No ☐ Unsure

Preferred Pharmacy Name

Pharmacy Address

Pharmacy Phone Number

Pharmacy Fax Number

Allergies

Allergies	Type	Severity	Reactions

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

Past Medical History

Past Medical History

Have you been diagnosed with any of the following?

- ☐ Cardiovascular
  - ☐ Abnormal heart rhythm
  - ☐ Blood clots
  - ☐ Congestive heart disease
  - ☐ Heart attack
  - ☐ Heart disease
  - ☐ High blood pressure
  - ☐ High cholesterol
- ☐ Pulmonary
  - ☐ Asthma
  - ☐ COPD
  - ☐ Cystic fibrosis
  - ☐ Pneumonia
  - ☐ Pulmonary embolism
  - ☐ Pulmonary hypertension
  - ☐ Sleep apnea
  - ☐ Tuberculosis
- ☐ Gastrointestinal
  - ☐ Cirrhosis
  - ☐ Colon Polyps
  - ☐ Crohn's disease
  - ☐ Gallstones
  - ☐ GERD
  - ☐ Hepatitis
  - ☐ Irritable bowel syndrome
  - ☐ Pancreatitis
  - ☐ Ulcerative colitis

- [ ] Genitourinary
  - [ ] Benign prostatic hypertrophy
  - [ ] Chronic kidney disease
  - [ ] Endometriosis
  - [ ] Erectile dysfunction
  - [ ] Frequent bladder infections
  - [ ] Frequent vaginal infections (BV, yeast)
  - [ ] Infertility
  - [ ] Interstitial cystitis
  - [ ] Kidney stones
  - [ ] Urinary incontinence
- [ ] Musculoskeletal/Connective Tissue
  - [ ] Chronic pain
  - [ ] Degenerative disc disease
  - [ ] Ehlers-Danlos syndrome
  - [ ] Fibromyalgia
  - [ ] Fracture(s)
  - [ ] Gout
  - [ ] Hypermobility syndrome
  - [ ] Osteoarthritis
  - [ ] Osteoporosis
  - [ ] Rheumatoid arthritis
  - [ ] Sciatica
- [ ] Endocrine
  - [ ] Diabetes, Type 1
  - [ ] Diabetes, Type 2
  - [ ] Hyperthyroidism
  - [ ] Hypothyroidism
  - [ ] PCOS
- [ ] Neurological
  - [ ] None
  - [ ] ADD/ADHD
  - [ ] Alzheimer's
  - [ ] Autism
  - [ ] Cerebral Palsy
  - [ ] Dementia
  - [ ] Headaches
  - [ ] Huntington's

- [ ] Meningitis
- [ ] Migraines
- [ ] Multiple sclerosis
- [ ] Muscular dystrophy
- [ ] Myasthenia gravis
- [ ] Neuropathy
- [ ] Parkinson's
- [ ] Seizures
- [ ] Stroke
- [ ] TIA
- [ ] Traumatic brain injury

- [ ] Allergy/Immune/Dermatology
  - [ ] Allergies
  - [ ] Anaphylactic reactions
  - [ ] Angioedema
  - [ ] Eczema
  - [ ] Hay fever/seasonal allergies
  - [ ] Hives
  - [ ] Immune deficiency
  - [ ] Psoriasis
- [ ] Psychiatric
  - [ ] Anxiety
  - [ ] Anorexia nervosa
  - [ ] Binge eating disorder
  - [ ] Bipolar disorder
  - [ ] Bulimia
  - [ ] Depression
  - [ ] Obsessive compulsive disorder
  - [ ] Schizophrenia
- [ ] Miscellaneous
  - [ ] Cancer
  - [ ] Cataracts
  - [ ] Chronic sinusitis
  - [ ] Glaucoma
  - [ ] Deviated Septum
  - [ ] Addiction
- [ ] None

☐ Other _____

Comments _____

Past Medical History

Have you undergone any of the following surgeries?

☐ Cardiovascular
- ☐ Aneurysm repair
- ☐ Arrhythmia surgery or ablation
- ☐ Carotid endarterectomy
- ☐ Carotid stenting
- ☐ Congenital heart surgery
- ☐ Coronary artery bypass graft (CABG)
- ☐ Coronary artery stenting
- ☐ Heart valve repair or replacement
- ☐ Insertion of cardiac device (pacemaker, defibrillator, etc)
- ☐ Vascular bypass
- ☐ Varicose vein treatment

☐ Pulmonary
- ☐ Thoracotomy

☐ Gastrointestinal
- ☐ Appendectomy (appendix removal)
- ☐ Bariatric surgery
- ☐ Cholecystectomy (gallbladder removal)
- ☐ Hernia repair
- ☐ Nissen fundoplication (reflux, GERD surgery)

☐ Genitourinary
- ☐ Breast biopsy or mastectomy
- ☐ Cesarean section
- ☐ Cystoscopy (bladder scope)
- ☐ Exploratory laparoscopy (for diagnosis of endometriosis)
- ☐ Hysterectomy (uterus removal +/- other organs)
- ☐ Kidney or ureter surgery
- ☐ Prostate surgery (biopsy, resection)
- ☐ Tubal ligation (female sterilization)
- ☐ Uterine ablation
- ☐ Vasectomy (male sterilization)

☐ Musculoskeletal/Connective Tissue
- ☐ Arthroscopy (scope)

- ☐ Back surgery
- ☐ Carpal tunnel release
- ☐ Neck surgery
- ☐ Fracture repair (requiring surgery)
- ☐ Total or partial joint replacement

☐ Endocrine

- ☐ Thyroidectomy (partial or total removal of thyroid gland)

☐ Allergy/Immune/Dermatology

- ☐ Mohs surgery (for skin cancer)

☐ Miscellaneous

- ☐ Cataract surgery
- ☐ Tonsillectomy

☐ None

☐ Other _____

Comments _____

Past Medical History

Have you ever been pregnant?

☐ Yes, not currently pregnant ☐ Yes, currently pregnant ☐ No
☐ N/A

If yes, have you had any of the following complications?

☐ Eclampsia ☐ Ectopic pregnancy ☐ Gestational diabetes
☐ Gestational hypertension (high blood pressure)
☐ Hyperemesis gravidarum ☐ Iron deficiency anemia
☐ Miscarriage ☐ Preeclampsia ☐ Postpartum anxiety
☐ Postpartum depression ☐ None
☐ Other _____

If you have given birth before, please list the dates and type of deliveries (vaginal, cesarean):

Social History

Social History

Marital status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Separated ☐ In a relationship
☐ Other _____

Comments _____

Are you currently sexually active?

☐ Yes ☐ No

Comments _____

In your home, do you:

☐ Live alone ☐ Live with others

Comments _____

Do you have any children? If yes, please list names and ages.

☐ Yes ☐ No

Comments _____

What is your highest level of education?

☐ High school ☐ GED ☐ Some college ☐ College degree
☐ Graduate degree
☐ Other _____

Are you currently working? If yes, please state your occupation.

☐ Yes ☐ No

Comments _____

In a typical week how much alcohol do you consume?

☐ < 7 drinks ☐ 7-14 drinks ☐ >14 drinks

Comments _____

Do you or have you previously used cigarettes/tobacco products? If yes, please describe type, duration and quit date if applicable.

☐ Yes ☐ No

Comments _____

Have you ever used or are currently using any of the following substances? If yes, please provide further description.

- ☐ Cannabis/Marijuana
  - ☐ Current use
  - ☐ Past use
- ☐ Cocaine
  - ☐ Current use
  - ☐ Past use
- ☐ Heroin
  - ☐ Current use
  - ☐ Past use
- ☐ Hallucinogens (LSD, PCP, mushrooms)
  - ☐ Current use
  - ☐ Past use
- ☐ MDMA (ecstasy, Molly)
  - ☐ Current use
  - ☐ Past use
- ☐ Prescription drug abuse
  - ☐ Current use
  - ☐ Past use
- ☐ None
- ☐ Other _____

Comments _____

Family History

Family History

Family history of thyroid problems? If yes, please describe (relation to you, type of condition if known).

☐ Yes ☐ No

Comments _____

Family history of diabetes? If yes, please describe (relation to you, type 1 vs 2 if known.

☐ Yes ☐ No

Comments _____

Family history of heart disease? If yes, please describe (relation to you, further details if known).

☐ Yes ☐ No

Comments _____

Family history of stroke? If yes, please describe (relation to you).

☐ Yes ☐ No

Comments _____

Family history of high blood pressure? If yes, please describe (relation to you).

☐ Yes ☐ No

Comments _____

Family history of arthritis? If yes, please describe (relation to you, type of condition if known).

☐ Yes ☐ No

Comments _____

Family history of autoimmune condition? If yes, please describe (relation to you, type of condition if known).

☐ Yes ☐ No

Comments _____

Family history of addiction? If yes, please describe (relation to you, further details if known).

☐ Yes ☐ No

Comments _____

Family history of mental health conditions? If yes, please describe (relation to you, type of condition if known - anxiety, depression, etc).

☐ Yes ☐ No

Comments _____

Family history of cancer? If yes, please describe (relation to you, type of cancer and age at diagnosis if known).

☐ Yes ☐ No

Comments _____

Family history of other conditions? If yes, please describe (relation to you, type of condition if known).

☐ Yes ☐ No

Comments _____