Integrative Family Medicine of Asheville, PLLC

Comprehensive • Affordable • Primary & Urgent Care

Thank you for scheduling your Annual Physical with Integrative Family Medicine. Please fill out this brief intake so we can learn of any updates in your health history since your last annual exam. The more honest and complete you can be with your answers, the better we will be able to help you.

If for any reason you need to cancel your appointment, we ask that you give us 24 hours notice. We reserve the right to charge you for your appointment if less than 24 hours notice is given.

Full payment is due at time of service

For Medicare and Medicaid Patients Only:

The services we provide are currently not reimbursable under Medicare or Medicaid. At this time, you may not submit our invoices for reimbursement. However, referrals to specialists, hospitals, and for procedures such as x-rays or MRI would still be covered by Medicare or Medicaid.

For any questions regarding your appointment or these forms, please call us at (828) 575-9600. We look forward to seeing you again.

PLEASE PRINT AND COMPLETE IN FULL

***Please fill in all the information below, even if you think we have it listed on file correctly.**

Date_____

Patient's Legal Name:

_____ Nickname_____
Last First M

Is Patient enrolled in Medicare or Medicaid?_____

If Patient is a minor, Parent/Guardian's Name_____

Email Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

Patient's Mailing Address_____ZipCode_____

Name and Relationship of Emergency Contact _____

Phone number of Emergency Contact_____

Health History

What are your goals for this visit?

_____
_____
_____

Prioritize your most important health concerns today :

	Concern	Onset	Frequency	Severity
	Ex: Headache	June 1978	4 times/wk	mild/mod/severe
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Please advise us of any milestones or goals reached over this past year, any challenges, and any new barriers to good health:

_____
_____
_____

Any dietary changes? Please describe:

_____

Any exercise changes? Please describe

_____

Any occupational changes? Please describe

_____

Any changes in your family's health history? Any new diagnoses?

_____

Any new drug allergies, hospitalizations, or surgeries?

_____
_____
_____

Any updated vaccinations given?

_____

How is your energy level?

_____

Have there been any changes in your person health history? (Depression, Ear Problems, etc.)

_____

Substances

	Amount per Day	Amount per Week	Never Used	Past History of Use
Cigarettes	_____	_____	_____	_____
Cigars/Pipe/Chewing	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Other Drugs/Substances	_____	_____	_____	_____

Preventative Screenings

Date of last Colonoscopy_____

Date of last Pap Exam (Women) _____ History of abnormal Pap Exam? _____

Date of last Mammogram (Women) _____ History of abnormal Mammogram?_____

Date of last Prostate Exam (Men) _____ History of abnormal Prostate Exam?_____

Date of last Dexa Scan (Bone Density Test) _____

Sexual and Relationship History

Are you currently in a relationship? _____ yes _____ no Is it monogamous? _____ yes _____ no

Are you happy with your current sex life? _____ yes _____ no
Do you feel safe in your current relationship? _____ yes _____ no

Please describe the method of contraception you are currently using:_____
Experiences with current method:_____

Women Only

If applicable: **First day of most recent menstrual period_____ # of days between periods_____**

Do you have (please circle): Painful Periods Missed Periods Spotting Between Periods Vaginal Bleeding

Any unusual discharge, discomfort, infection, or recurring vaginal infections, and if so, what kind?

_____

***If you have gone through menopause*: Have you had any post menopausal bleeding? _____**

Number of: Pregnancies_____ Live Births_____ Abortions_____ Miscarriages_____

Have you experienced complications during pregnancy/delivery/other problems? _____

PRESCRIPTION MEDICATIONS - Please list on the table below ALL prescription medication you take or use.

Name of Medication (Brand name) and **Strength**	**How were you told to take this medication?**	**How often do you take/use this medication?**	**How much do you take/use for each dose?**	**When did you begin taking this medication?**	**Condition treated with this medication**	**When did you stop taking this medication?**	**Why did you stop taking this medication?**

NONPRESCRIPTION MEDICATIONS AND SUPPLEMENTS CURRENTLY OR RECENTLY TAKEN
(Vitamins, Minerals, Herbs, Herbal products, Remedies, and Other health products)

Brand name of Product and list of Ingredients	**Dosage**	**Amount per dose**	**Frequency**	**When did you begin?**	**Reason for this supplement**	**When did you stop?**	**Why did you stop taking this product?**

*Please use the back of this sheet as needed

Other Providers on Your Health/Wellness Team

Please list the name and title of all other providers currently supporting you (ie. acupuncturist, physical therapist, specialists, etc.):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Any additional notes: