The Wholistic Family Wellness Center

Dr. Concetta Oteri

Date _____

FEMALE ADULT NEW PATIENT PROFILE

A note to our patients: Please complete this as thoroughly as possible. This is a confidential record of your medical information and will not be released, except under the guidelines of the Notices of Privacy Practices.

Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City:_____ State: _____ Zip: _____

Please circle the phone number at which you prefer to be reached.
Telephone: Home _____ Work _____ Cell _____

Please leave messages regarding your medical care at: Home [ ] Work [ ] Cell [ ]

Email: _____
I would like to receive quarterly E-newsletters [ ]

Family members who live with you and their ages, relationship to you, and health:
_____
_____
_____
_____
_____

Occupation: _____ Employer _____
Emergency Contact: _____ Relationship_____ Phone _____

Other current health care providers (naturopath, chiropractor, herbalist, homeopath, massage therapist, psychologist, counselor, or any specialists):
_____
_____
_____

Who can we thank for referring you to The Wholistic Family Wellness Center?
_____

Name _____Date:_____ Age:_____

Medical History

Have you had or do you have any of the following:
(Please circle)

Alcoholism/drug abuse
Allergies
Anxiety
Asthma/emphysema
Arthritis
Blood in stool
Cancer
Chronic skin problems/rash
Colitis
Constipation
Depression
Diabetes
Diarrhea
Difficulty achieving orgasm
Difficulty swallowing
Diverticulitis
Double/blurred vision
Epilepsy/seizures
Exposure to HIV
Frequent/severe headaches
Gall bladder problem
Heart attack
Heart disease
Hepatitis
Hernia
High blood pressure
High cholesterol
Impotence
Kidney/bladder infections
Kidney stone
Loss of hearing
Loss of vision
Lyme disease
Osteoporosis/osteopenia
Pneumonia
Positive TB skin test
Rheumatic fever
Sexually transmitted disease:
(circle if you have ever had)
Gonorrhea
Chlamydia
Syphilis
Herpes
HPV/warts
Sinus problems
Stroke/mini-stroke
Swelling in legs/feet
Tuberculosis
Thyroid problems
Vomiting blood
Weight loss/gain

Are you experiencing any health problems today? If so, please describe:
_____
_____
_____
___
Please list any surgeries or hospitalization:
_____
_____
_____
___
Please list and describe any medication allergies:
_____
_
_____
_____
__
Please list all medication/supplements that you are taking (include doses and reason for taking):
_____
_____
_____
_____
_____
_____
_____
_____
_____

Family History

Have your parents, siblings, or grandparents ever had any of the following: (please circle)

Diabetes	Alcoholism/drug abuse	Depression/bipolar
Cancer type_____	Heart attacks/heart disease	High cholesterol
Thyroid problems	High blood pressure	Rheumatoid arthritis/lupus
Stroke	Osteoporosis	Other_____

Name _____Date:_____ Age:_____

Sexual History

Which of the following contraceptive methods are you using: (please circle)

Natural Family Planning Foam		Other_____
Condoms	Vasectomy	None, same sex preference
Birth control pills	Tubal ligation	None, trying to get pregnant
Diaphragm	IUD: type_____	

How long have you been with your current sex partner? _____
Have you ever been raped or abused sexually? Yes No

Sleeping Habits

Are you having difficulty sleeping? Yes No
Is stress in your life causing you to lose sleep? Yes No
Have your sleeping habits changed recently? Yes No
Hours of sleep per night: _____

Eating Habits

Have you gained or lost a significant amount of weight recently? Yes No
If yes, how much? _____
Are you concerned about your current eating habits? Yes No
Do you consider your diet healthy? Yes No
Please describe your diet: _____
Are you having problems with over-eating? Yes No
Do you think you may have an eating disorder? Yes No
What do you think is your perfect weight?_____

Personal Habits

Do you smoke cigarettes? Yes No How many per day? _____
Do you have regular bowel movements? Yes No How often? _____
Do you exercise regularly? Yes No What, for how long, and how often?_____
Do you drink alcohol? Yes No What type and how much per week?_____
Do you feel overly stressed in your daily life? Yes No
Are you currently experiencing any feeling of depression? Yes No
Have you recently experienced any events that increase your stress level? Please describe:
_____
_

Menstrual/Pregnancy History

Age of first period: _____ Usual length of period: _____
Age of first intercourse: _____ Usual interval between periods: _____
Describe your menstrual flow:_____

Number of:

Total Pregnancies: _____ Abortion/miscarriage:_____
Still births: _____ Full term deliveries:_____
Preterm delieveries: _____ Ectopic pregnancies:_____

Have you had any of the following: (please circle)

Abnormal breast lumps	Infection in ovaries/fallopian tubes	Ovarian cyst
Abnormal pap smear	Infertility	Painful periods
DES exposure	Irregular periods	