Primavita Family Medicine, PLLC

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Welcome to our clinic! *Please answer all questions as thoroughly as possible to assist Dr. Shinsato in providing you the best care possible. This form is confidential and the information will not be released to anyone outside this clinic without your written permission.*

Please mail or fax this form to us 2-3 days before your visit so Dr. Shinsato may review your health profile. *Otherwise, please bring the completed form with you to your visit. If you have any questions, please make a note and ask Dr. Shinsato for clarification during your visit.*

If you have a good experience with our clinic, please tell others! *If you did not have a good experience with us, please tell us, we appreciate your feedback to help us serve you better. Thank you for your assistance!*

ADULT HEALTH PROFILE

Today's Date: _____

Name:_____ Sex: M F

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

Phone: Home: _____ Work: _____ Cell:_____

E-mail Address: _____

How do you prefer to be contacted? ❒ Home ❒ Cell ❒ Work ❒ Email

Email correspondence is available for patient's for questions regarding their current treatment plan. Email is considered to be unsecured and is not recommended for the discussion of certain sensitive health related conditions. I agree to email correspondence for treatment plan clarifications and understand that it is considered unsecured. ***Please Initial*** _____

May we leave messages on your phone relating to your visits? Y N
May we send you clinical information? Y N

Date of birth:_____ Age:_____ Blood Type: _____Ht:_____Wt:_____
Are you pregnant, planning or lactating?_____ Ethnicity: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us: _____

Current Health Care Provider(s):	*Type*	*Phone*	*Fax*

Primary Health Concerns: Please prioritize 1 or 2 health concerns that you would like to address during your first appointment.	*Prior Diagnoses*	*Prior Labs/Imaging*	Prior Treatments

Note: If there is an extensive history associated with your health concern(s), please attach a separate piece of paper with a timeline of events, including symptoms, diagnoses, lab tests, treatments, what has helped and what has not helped.

Please list other symptoms or concerns that you have:

_____
_____
_____

How did these conditions develop? Can you identify any traumatic events that may have caused or aggravated your health problems? What happened in your life around this time?

_____
_____
_____

Have you ever consulted: ❒ Naturopathic Physicians ❒Acupuncturists ❒Chiropractors ❒ Nutritionists ❒Other_____

What level of change to your living habits are you willing to make to improve your health and address underlying causes of your signs and symptoms? (0% being no commitment, 100% complete commitment)

0% 10 20 30 40 50 60 70 80 90 100%

What goals do you have for your visit today?

What long-term expectations do you have for working with Primavita?

MEDICAL HISTORY

How would you describe your general state of health? ❒Excellent ❒Good ❒Fair ❒Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with appropriate dates:

_____
_____

MEDICATIONS:

Do you take or use the following?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisol	Y N	Antibiotics	Y N	Appetite suppressants	Y N
Tranquilizers	Y N	Thyroid medications	Y N	Sleeping aids	Y N

Aspirin Y N Birth Control Y N Type?_____
List all the drugs (prescription and over the counter pharmaceuticals) including dosages.
1. _____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Are you sensitive/allergic to any drugs, foods, chemicals, animals, environmental substances? ❒Y ❒N
If yes, please list:_____
_____
_____
What happens when you have an "allergy attack"? _____
_____
What prior types of allergy testing have you had? _____

CURRENT SUPPLEMENTS:
List all vitamins, minerals, herbs, homeopathic, with dosages:
1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Over the last 2 years, how many times have you been treated with antibiotics, for what condition?_____
_____
_____
_____

PAST MEDICAL HISTORY

Your Prenatal/birth/feeding history:
Describe your mother's pregnancy with you: ❒Natural ❒Forceps ❒Epidural ❒C-section ❒Trauma
_____
Breast fed?_____ how long?_____ Formula (kind):_____how long?_____

What childhood illnesses have you had?

❒Rubella (German 3 day measles)	❒Measles (2 week)	❒Mumps	❒Chickenpox
❒Whooping Cough	❒Rheumatic Fever	❒Polio	❒Scarlet Fever
❒Roseola	❒Asthma	❒Thrush	❒Epilepsy
❒Mononucleosis	❒Strep Throat	❒Ear infections	❒Colic
❒Rashes/cradle cap	❒Constipation	❒Jaundice	❒Headaches

Immunizations: ❒Polio ❒Tetanus ❒Measles/Mumps/Rubella ❒Pertussis ❒Diphtheria
❒Hepatitis B ❒Chicken Pox ❒H. influenza ❒Flu shot ❒Other (for travel)_____

Major Illnesses/emotional or physical trauma/ accidents (not already listed):

Type	Date	Treatment Received	Outcome

Outpatient Procedures / Hospitalizations, surgeries/ special diagnostic studies:

Type of surgery/study	Date	Reason for procedure	Outcome/Results

Recent physical exam: Date: _____Results: _____❒ normal
Recent blood work/ urine test: Date: _____Results: _____❒ normal
Recent PAP/ pelvic or prostate exam: Date: _____Results: _____❒ normal
Recent mammogram (females over 40): Date: _____Results: _____❒ normal

LIFESTYLE

Are you currently: ❒Single ❒Married ❒Partnership ❒Separated ❒Divorced ❒Widowed
Live with: ❒Spouse ❒Partner ❒Parents ❒Children ❒Friends ❒Alone
Are you sexually active? (circle one) Yes No If yes, is it with (circle one): male female both
Do you or your partner(s) use any form of contraception? Yes No If so, what type(s)? _____
Are you pregnant? Yes No Trying to get pregnant? Yes No If so, how far along ? _____
Do you have children? Yes No How many? _____ Names/ ages/ and health or wellness issues:
_____
_____
How would you describe your general health? _____
What is your current job or position? _____
Are you happy in your job or career? ❒Yes ❒No_____
What personal goals do you have?_____
What makes you happy?_____
What are you grateful for?_____
What is your individual & unique purpose in this life?_____
Religious/spiritual affiliation_____
What would you like to change most about your life?_____
_____
What behaviors, habits, or thoughts would you like to eliminate?_____
_____
Is your present sex life satisfactory?_____
Do you drink alcohol? ❒Yes ❒No How often?: wine_____beer_____other alcohol_____
Do you use tobacco or have you in the past? ❒No ❒Yes, How long? _____ How much daily?_____
Do you now or have you in the past used recreational drugs? ❒Yes ❒No _____
Have you ever been exposed to toxic chemicals, solvents or other possible harmful toxins? ❒Yes ❒No
If yes, please explain_____
_____
Do you exercise? ❒Yes ❒No What form(s)?_____
How often?_____
Do you make time for rest, relaxation or meditation during the day and/or before bed? ❒Yes ❒No
How often? _____How do you relax?_____
What are your interests or hobbies?_____
Which of the following do you do regularly: ❒Jogging ❒Swimming ❒Walking ❒Biking ❒Gardening
❒Yoga ❒Breathing ❒Exercises ❒Meditation ❒Weightlifting ❒Pilates ❒Pray
Other activities: _____
Do you use regularly? ❒Chemical hair treatments ❒Electric blanket ❒Heating pad
❒Cosmetics ❒perfumes ❒pesticides around the home ❒Dry cleaning ❒Computer

Are your home and/or work environments well ventilated? ❒Yes ❒No Mold? ❒Yes ❒No
Are there unusual/unpleasant smells in your work/living environment? ❒Yes ❒No
When were the ducts in your home last cleaned?_____

DIET

How many meals do you generally eat each day? ❒One ❒Two ❒Three ❒More than three
Do you: ❒eat out often ❒diet frequently ❒skip meals frequently
Do you have any special diet or eating restrictions? ❒Yes ❒No if yes, please explain_____
_____
List the primary foods you include in your diet?_____
List the foods you exclude from your diet_____
Mark which of these you consume regularly ❒Coffee ❒Caffeinated teas ❒Artificial sweeteners
❒Processed foods ❒Preservatives ❒Refined foods ❒Margarine ❒Fast Food ❒Soda
List any other foods you eat which you suspect may be harmful to your health_____
List any foods you crave, regardless of their nutritional value (include sweets, chocolate, bread, salty, sour, rich, fatty foods, etc.)_____
List any foods to which you have a bad reaction:_____
Are you thirsty often? ❒Yes ❒No At night? ❒ Yes ❒No How much water do you drink daily?_____
What temperature do you prefer to drink? ❒Hot ❒Cold ❒Room Temp.
Are you satisfied with your diet as it is now? ❒Yes ❒No If no, why not?_____
_____

SLEEP

Do you have trouble falling asleep? ❒Yes ❒No If yes, what keeps you up?_____
_____
Do you wake at night and can't fall back to sleep? ❒Yes ❒No_____
Do you wake feeling refreshed? ❒Yes ❒No_____
Do you have recurring dreams? ❒Yes ❒No If yes, what is the theme?_____
_____
_____

FAMILY MEDICAL HISTORY

(Please list ages and if deceased, what they passed from and at what age)

Mother's Side	**Father's Side**
Grandfather_____	Grandfather_____
Grandmother_____	Grandmother_____
Mother_____	Father_____
Your Sisters _____	
Your Brothers_____	

Has any BLOOD RELATIVE had any of the following:

❒Anemia	❒Kidney Disease	❒Arthritis
❒Heart Disease	❒Mental Illness	❒Autoimmune Condition
❒Asthma/Hay Fever/Hives	❒High Blood Pressure	❒Alzheimer's
❒Bleeding Disorder	❒Seizure/Epilepsy	❒Alcoholism/Addiction
❒Cancer	❒Sickle Cell/Thalassemia	❒Obesity
❒Diabetes	❒High Cholesterol	❒Osteoporosis
❒Thyroid (hyper/hypo)	❒Liver Disease	❒Glaucoma
❒Eczema	❒Tuberculosis (TB)	❒Stroke
❒ Other_____	❒Other_____	❒Other_____

GENERAL STATUS

Height _____ Weight _____ lbs. Ideal Weight_____
Weight 1 year ago _____ lbs. Max. Weight _____ When _____
When during the day is your energy the best? _____ Worst? _____

Listed below are factors which may or may not influence your state of being. Please check the appropriate box of ONLY those with SIGNIFICANT influence on your health.

BETTER	WORSE		BETTER	WORSE	
❒	❒	Winter	❒	❒	Spring
❒	❒	Summer	❒	❒	Autumn
❒	❒	Cold	❒	❒	Heat
❒	❒	Dampness	❒	❒	Dryness
❒	❒	Open air (being outside)	❒	❒	Windows closed
❒	❒	Change of weather	❒	❒	Traveling
❒	❒	Ocean seashore	❒	❒	Mountains
❒	❒	Physical exertion	❒	❒	Upon rising
❒	❒	Morning	❒	❒	Evening
❒	❒	Cold application	❒	❒	Warm application
❒	❒	Bath	❒	❒	Before menstruation
❒	❒	During menstruation	❒	❒	After menstruation

Other things that make you significantly better or worse:_____
_____

REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE
Y = a condition you now have, N = Never had, P = a condition you have had in the past

MENTAL/ EMOTIONAL

Treated for emotional problems?	Y	P	N	Depression?	Y	P	N
Mood Swings?	Y	P	N	Anxiety or nervousness?	Y	P	N
Considered/Attempted suicide?	Y	P	N	Tension?	Y	P	N
Poor concentration?	Y	P	N	Memory problems?	Y	P	N
Do you have concerns with abuse / violence in your life?					Y	P	N

SKIN

Rashes?	Y	P	N	Eczema, Hives?	Y	P	N
Acne, Boils?	Y	P	N	Itching?	Y	P	N
Color Change?	Y	P	N	Perpetual Hair Loss?	Y	P	N
Lumps?	Y	P	N	Night Sweats?	Y	P	N

HEAD

Headaches?	Y	P	N	Head Injury?	Y	P	N
Migraines?	Y	P	N	Jaw/TMJ problems	Y	P	N

EYES

Spots in Eyes?	Y	P	N	Cataracts?	Y	P	N
Impaired vision?	Y	P	N	Glasses or contacts?	Y	P	N
Blurriness?	Y	P	N	Eye pain/strain?	Y	P	N
Color blindness?	Y	P	N	Tearing or dryness?	Y	P	N
Double Vision?	Y	P	N	Glaucoma?	Y	P	N

EARS

Impaired hearing?	Y	P	N	Ringing?	Y	P	N
Earaches?	Y	P	N	Dizziness?	Y	P	N

NOSE AND SINUSES

Frequent colds?	Y	P	N	Nose Bleeds?	Y	P	N
Stuffiness?	Y	P	N	Hay fever?	Y	P	N
Sinus problems?	Y	P	N	Loss of smell?	Y	P	N

MOUTH AND THROAT

Frequent sore throat?	Y	P	N	Copious saliva?	Y	P	N
Teeth grinding?	Y	P	N	Sore tongue/lips?	Y	P	N
Gum problems?	Y	P	N	Hoarseness?	Y	P	N
Dental cavities?	Y	P	N	Jaw clicks?	Y	P	N

NECK

Lumps?	Y	P	N	Swollen glands?	Y	P	N
Goiter?	Y	P	N	Pain or stiffness?	Y	P	N

RESPIRATORY

Cough?	Y	P	N	Sputum?	Y	P	N
Spitting up blood?	Y	P	N	Wheezing	Y	P	N
Asthma?	Y	P	N	Bronchitis?	Y	P	N
Pneumonia?	Y	P	N	Pleurisy?	Y	P	N
Emphysema?	Y	P	N	Difficulty breathing?	Y	P	N
Tuberculosis?	Y	P	N	Shortness of breath?	Y	P	N
Shortness of breath at night?	Y	P	N				
Shortness of breath lying down?	Y	P	N				

CARDIOVASCULAR

Heart disease?	Y	P	N	Angina?	Y	P	N
High/Low Blood Pressure?	Y	P	N	Murmurs?	Y	P	N
Blood clots?	Y	P	N	Fainting?	Y	P	N
Phlebitis?	Y	P	N	Palpitations/Fluttering?	Y	P	N
Rheumatic Fever?	Y	P	N	Chest pain?	Y	P	N
Swelling in ankles?	Y	P	N				

GASTROINTESTINAL

Trouble swallowing?	Y	P	N	Heartburn?	Y	P	N
Change in thirst?	Y	P	N	Change in appetite?	Y	P	N
Nausea?	Y	P	N	Vomiting?	Y	P	N
Vomiting blood?	Y	P	N	Bowel Movements: How often?			
Blood in stool?	Y	P	N	Is this a change?			
Pain or cramps?	Y	P	N	Constipation?	Y	P	N
Belching or passing gas?	Y	P	N	Diarrhea?	Y	P	N
Black stools?	Y	P	N	Gall Bladder disease?	Y	P	N
Jaundice (yellow skin)?	Y	P	N	Ulcer?	Y	P	N
Liver Disease?	Y	P	N	Hemorrhoids?	Y	P	N

Genitals

Chlamydia?	Y	P	N	Herpes?	Y	P	N
Gonorrhea?	Y	P	N	Syphilis?	Y	P	N
Hernias?	Y	P	N	Warts?	Y	P	N
Has anyone touched you in a way that made you uncomfortable without your permission					Y	P	N

Male

Testicular masses?	Y	P	N	Impotence?	Y	P	N
Testicular pain?	Y	P	N	Prostate disease?	Y	P	N
Low sperm count?	Y	P	N	Premature ejaculation?	Y	P	N

Female

Age of first menses?	_____			Menopausal symptoms?	Y	P	N
Are cycles regular?	Y		N	Age of last menses?	_____		
Length of cycle?	_____days			Bleeding between cycles?	Y	P	N
Duration of menses?	_____days			Pain during intercourse?	Y	P	N
Painful menses?	Y	P	N	Clotting?	Y	P	N
Heavy or excessive flow?	Y	P	N	Discharge?	Y	P	N
PMS?	Y	P	N	Birth control?	Y	P	N
If yes, what are your symptoms?	_____			What type?	_____		
Number of pregnancies	_____			Number of live births	_____		
Endometriosis?	Y	P	N	Number of miscarriages	_____		
Ovarian cysts?	Y	P	N	Number of abortions	_____		
Sexual difficulties?	Y	P	N	Difficulty conceiving?	Y	P	N
Cervical Dysplasia?	Y	P	N	Abnormal PAP?	Y	P	N
Do you do breast self exams?	Y	P	N	Breast lumps?	Y	P	N
Breast pain/tenderness?	Y	P	N	Nipple discharge?	Y	P	N

URINARY

Pain on urination?	Y	P	N	Increased frequency?	Y	P	N
Frequency at night?	Y	P	N	Inability to hold urine?	Y	P	N
Frequent infections?	Y	P	N	Kidney stones?	Y	P	N

ENDOCRINE

Hypothyroid?	Y	P	N	Heat or cold intolerance?	Y	P	N
Hypoglycemia?	Y	P	N	Diabetes?	Y	P	N
Excessive thirst?	Y	P	N	Excessive hunger?	Y	P	N
Fatigue?	Y	P	N	Seasonal depression?	Y	P	N

IMMUNE

Vaccinations?	Y	P	N	Reactions to vaccinations?	Y	P	N
Chronic Fatigue Syndrome?	Y	P	N	Chronic infections?	Y	P	N
Chronically swollen glands?	Y	P	N	Slow wound healing?	Y	P	N

NEUROLOGIC

Seizures?	Y	P	N	Paralysis?	Y	P	N
Muscle weakness?	Y	P	N	Numbness or tingling?	Y	P	N
Loss of memory?	Y	P	N	Easily stressed?	Y	P	N
Vertigo or dizziness?	Y	P	N	Loss of balance?	Y	P	N

MUSCULOSKELETAL

Joint pain or stiffness?	Y	P	N	Arthritis?	Y	P	N
Broken bones?	Y	P	N	Weakness?	Y	P	N
Muscle spasms or cramps?	Y	P	N	Sciatica?	Y	P	N

BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising?	Y	P	N	Anemia?	Y	P	N
Deep leg pain?	Y	P	N	Cold hands/feet?	Y	P	N
Varicose veins?	Y	P	N	Thrombophlebitis?	Y	P	N

How would you describe the emotional climate of your home? _____
_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?
_____
_____
_____

Is there anything that you feel is important that has not been covered?
_____
_____
_____

Thank you for taking the time to fill out this form! It helps me to provide you with the best care possible. I look forward to working with you! -Dr. Shinsato