Cheryl A. Kasdorf N.M.D.

Patient Intake Form date _____

name: _____birthdate _____phone ( ) _____

email address _____ height _____ weight _____

mailing address _____zip _____

occupation _____ employer _____ work phone ( ) _____

spouse? _____ children? _____ emergency phone ( ) _____

last physician consulted _____ reason _____ date _____

how were you referred here _____reason for today's visit _____

current conditions / health concerns _____

_____

allergies or reactions to drugs or vaccinations? _____

current meds or supplements with dosage _____

_____

_____

do you have pets? _____dogs _____cats _____birds _____horses _____ other

do you smoke now? **Y N** in past? **Y N** how long? _____ how many packs? _____

do you exercise? **Y N** in what form? _____

do you use recreational drugs? **Y N** do you drink alcoholic beverages **Y N** amount _____

were you breast fed? **Y N** how is your current state of health? _____

how has your health been most of your life? _____

describe your job / daily activities _____

how is your family / home life? _____

how is your sleep? _____

What do you enjoy most in life? _____

What are your main interests or hobbies? _____

What do you most worry about in life? _____

have you recently had any changes in your: if yes, please explain

marital status	**Y**	**N**	_____
job or work	**Y**	**N**	_____
residence	**Y**	**N**	_____
financial status	**Y**	**N**	_____
appetite or weight	**Y**	**N**	_____

(more on other side)

PERSONAL HISTORY: currently, or in the past have you experienced any of the following? state year in the space

_____abuse _____headaches _____prostate problems

_____allergies _____heart disease _____skin disease

_____arthritis _____hepatitis _____short of breath

_____asthma _____herpes _____stomach / intestinal disorders

_____back injury _____high blood pressure _____tested positive for HIV

_____chronic diarrhea / constipation _____high / low blood sugar _____thyroid disease

_____depression _____physical trauma / fractures _____venereal disease

childhood illnesses: immunizations ? _____

_____measles _____mumps _____chicken pox _____german measles _____rheumatic fever

_____mono _____polio _____eczema _____other

have you had any serious illness or surgery, and when? _____

_____

_____

how much/often do you eat or drink: soft drinks_____ water_____ coffee / black tea_____

milk/dairy products _____ red meat/pork_____ poultry _____ fish _____

sweets _____ salty foods_____ baked goods _____ whole grains _____

green vegetables _____ other vegetables _____ fruit _____ beans/legumes _____

FAMILY HISTORY: please indicate past or present family conditions

_____asthma _____blood disorders _____migraines _____stomach/intestine disorders

_____arthritis _____cancer _____heart disease _____stroke

_____allergies _____depression _____high blood pressure _____thyroid condition

_____alcoholism _____diabetes _____skin disease _____mental disorder

_____other _____

RELATIVE HEALTH STATUS AGE if deceased, cause & age of death

father _____

mother _____

siblings_____