# Arcana Center for Integrative Medicine

Patient's Name: _____ Date of Birth: _____

**Reason for today's visit:** _____
_____
_____
_____
_____
_____

**Past Medical History**

Primary care physician: _____ Date of last exam: _____ (sick or well)

Physician's Address: _____ Office number: _____

**Allergies**
Are you/your child allergic to penicillin or any other drugs, food, or other substances? ☐Yes ☐No
If Yes, please list:

1. Name of substance_____ Reaction? _____
2. Name of substance _____ Reaction? _____
3. Name of substance _____ Reaction? _____
4. Name of substance _____ Reaction? _____
5. Name of substance _____ Reaction? _____

**Medications** (prescription and other vitamins/supplements):

1. Name _____dose _____How many times a day_____
2. Name _____dose _____How many times a day_____
3. Name _____dose _____How many times a day_____
4. Name _____dose _____How many times a day_____
5. Name _____dose _____How many times a day_____

Have you/your child ever been hospitalized? ☐Yes ☐No If yes, when, where and what for?

1. When _____Where _____What for_____
2. When _____Where _____What for_____
3. When _____Where _____What for_____

4. When _____Where _____What for_____
5. When _____Where _____What for_____

**Are you/your child being treated or have you/your child ever been treated for any of the following conditions?**

- ○ Sinus problems
- ○ Seasonal allergies
- ○ Eye problems
- ○ Ear problems
- ○ Heart disease
- ○ Murmur
- ○ High cholesterol
- ○ High blood pressure
- ○ COPD
- ○ Asthma
- ○ other lung problems
- ○ Heartburn (reflux)
- ○ Ulcers
- ○ rectal bleeding
- ○ Hepatitis
- ○ Kidney problems
- ○ Bladder problems
- ○ Any Cancer
- ○ Diabetes
- ○ Thyroid problems
- ○ Stroke
- ○ Anemia or blood
- ○ Seizures
- ○ Arthritis
- ○ Headaches
- ○ Migraines
- ○ Neurologic problems
- ○ Neck pain
- ○ Skin problems
- ○ Depression
- ○ Anxiety
- ○ Back pain
- ○ Psychiatric care

**Please describe any current or past medical and dental treatment not listed above**

_____
_____
_____
_____

**Please list any past surgeries (including dental work) and the date(s) you/your child had them**

_____
_____
_____
_____

**Please list any sports and/or instruments you/your child has ever played (and the level)**

_____
_____
_____

**Please list any injuries, accidents or traumas you/your child has ever had**

_____
_____
_____
_____

**Your/Your child's Birth History:** (circle) Full-term Premature Late
C-section Forceps/vacuum Vaginal delivery

**Any complications during the parent's pregnancy, delivery or post-partum (back pains, infections, etc)?**

_____
_____
_____
_____

**Social and Preventive History**

Have you/your child ever used smoke/chew tobacco products, alcohol or marijuana ☐Yes ☐No
If yes, explain which, how much and current use? _____

Water intake per day: _____ Sodas (# per week)—Diet or regular? _____

Dietary restrictions/preference: _____

Describe your/your child's sports, instruments, activities, exercise routine, or level of activity:
_____
_____
_____

Immunizations hx: Did you/your child receive all routine childhood vaccinations? ☐Yes ☐No
If no, which shots were missed and why? _____
_____

Describe any difficulties you had or your child is having in school (ie. academic, social, emotional, physical, etc.)
_____
_____
_____

**Gyn history:** Number of pregnancies? _____

Full term: #_____ Pre-term: # _____ Abortions/miscarriage #_____

Symptoms of menopause/menopause? Yes or No

**Family History**
Living Age (or age at death) List serious illnesses
Mother Living? ☐Yes ☐No If no, age/cause at death_____
Father Living? ☐Yes ☐No If no, age/cause at death_____

How many siblings do you have?
Brothers_____Ages_____
Sisters____Ages_____
Are your siblings living? If no, age at death_____

Has any member of your/your child's family had any of the following illnesses:
*(List illness and which family member)*
Anemia or Blood disease _____
Cancer _____
Diabetes _____
Heart disease _____
High blood pressure _____
Mental Illness / Depression _____
Stroke _____
Musculoskeletal disorders (osteoarthritis, rheumatoid arthritis…)_____
Other serious illness _____

**REVIEW OF SYSTEMS**
Please mark any of the following symptoms that you/your child may currently have or within the last 3 months:

- ○ Changes in appetite
- ○ Fever/Chills
- ○ Weight loss
- ○ Weakness
- ○ Blurred/Double vision
- ○ Runny nose
- ○ Sinusitis
- ○ Nasal congestion

- ○ Mouth breathing
- ○ Problems with swallowing
- ○ Sore throat
- ○ Ear pain
- ○ Shortness of breath
- ○ Cough
- ○ Wheezing
- ○ Chest pain
- ○ Palpitations
- ○ Edema/swelling
- ○ Abdominal pain
- ○ Nausea
- ○ Bloating/belching
- ○ Flatulence
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Heartburn
- ○ Burning w/urination
- ○ Frequent urination
- ○ Urgency
- ○ Loss of bladder control
- ○ Weakness
- ○ Numbness
- ○ Problems with speech
- ○ Memory problems
- ○ Headaches
- ○ Migraines
- ○ Vertigo
- ○ Dizziness
- ○ Neck pain
- ○ Shoulder pain
- ○ Back pain
- ○ Hip pain
- ○ Knee pain
- ○ Ankle/foot pain
- ○ Elbow pain
- ○ Wrist/hand pain
- ○ Skin rash
- ○ Behavior problems

**By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.**

**Patient/Legal Guardian Signature** _____

**Date** _____