Be Well Medical
5510 W Chandler Blvd, Suite 3
Chandler, Arizona, US - 85226

Be Well Medical New Patient Intake (13+ Years)

Be Well Medical Center New Patient Intake (13+ years)

How did you hear about us (please be specific)?

Reason for your office visit:

CONTEX OF CARE REVIEW

What is your gender identity?

- ☐ Female
- ☐ Male
- ☐ FTM
- ☐ MTF
- ☐ Other

What is your preferred pronoun?

- ☐ She/Her
- ☐ He/Him
- ☐ They/Them
- ☐ Zoe/Zim
- ☐ Other

FAMILY HISTORY

Has any blood relative ever had any of the following? *

- ☐ Cancer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Heart Disease
- ☐ Mental illness or suicide
- ☐ Autoimmune Disease
- ☐ Osteoporosis
- ☐ None

If you checked an answer above please list who received the diagnosis in relation to you (maternal grandmother, paternal grandfather, mother, father, sibling, etc.) *

MEDICAL HISTORY

Please list your Primary Care Physician if applicable. Please include practice name, address, phone number and fax number.

Please list any other physicians who are currently involved in your care (i.e. cardiologist, endocrinologist, etc.)

Please list any prior illnesses, diagnoses or injuries including the date occurred.

Please list any and all prior surgeries and hospitalizations, including the date occurred.

Please list all medications that you are currently taking. Please include the dose, frequency that the medication is taken and the reason it was prescribed.

Medications

Medication Name	Intake Details

Please list all supplements that you are currently taking. Please include the dose, frequency that the supplement is taken and the reason for its use.

Supplements

Supplement Name	Intake Details

Please list any allergies to medications, foods or environmental allergies. Also include the type of reaction. If there are no allergies, list "none."

Allergies

Allergies	Type	Severity	Reactions

SOCIAL HISTORY

What is your current employment? ____________________

Have you done any foreign travel within the last year? * ☐ Yes ☐ No

Please indicate your average level of energy throughout the day using the scale 1-10 (1 being the lowest energy and 10 is the best energy) * ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please indicate any exercise done on a regular bases. Include how many days per week, and for how long.

SLEEP HISTORY

How many hours of sleep do you usually get per night? * ____________________

Do you wake refreshed? ☐ Yes ☐ No

Do you have difficulty sleeping? * ☐ Yes ☐ No

Do you have to use a sleep aid such as a medication? ☐ Yes ☐ No

ALCOHOL, TOBACCO, AND RECREATIONAL DRUG USE

Do you drink alcohol? * ☐ Yes ☐ No

If yes, how much do you drink per sitting and how frequently do you drink (daily, weekly, etc.)?

Do you use tobacco containing products? * ☐ Yes ☐ No

If yes, specify how much, how frequently, and for how long:

Do you use recreational drugs? * ☐ Yes ☐ No

If yes, please list what is used and how often:

Have you ever been told you have an addiction or been treated for an addiction? * ☐ Yes ☐ No

Does the use of alcohol or drugs impair your activities of daily living? ☐ Yes ☐ No

DIET HISTORY

Do you follow a specific diet? *

How many ounces of water do you drink daily? *

Please check if you drink any of the following: ☐ Soda ☐ Energy drinks ☐ Sports drinks

Do you drink coffee or any other caffeinated beverages? * ☐ Yes ☐ No

If so, please indicate what you drink and how much per day:

RELATIONSHIP HISTORY

What is your relationship status?

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Domestic partner
- ☐ Widowed
- ☐ In a relationship

Do you describe your childhood as:

- ☐ Mostly happy
- ☐ Normal
- ☐ Mostly painful

Do you have a history of abuse? Check all that apply.

- ☐ Mental abuse
- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Emotional abuse

At what age and by whom did the abuse occur?

REVIEW OF SYSTEMS

For the following section, please read the question and select any of the following that you have experienced within the last year or may have a history of.

General

- ☐ Weight change
- ☐ Appetite change
- ☐ Fever/chills
- ☐ Weakness
- ☐ Fatigue
- ☐ Night sweats

Eyes

- ☐ Dryness
- ☐ Watery eyes
- ☐ Itchy eyes
- ☐ Redness of the eye
- ☐ Eye strain
- ☐ Cataracts
- ☐ Styes
- ☐ Contact/glasses
- ☐ Glaucoma

Ears/Nose/Throat

- ☐ Ringing
- ☐ Change in hearing
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Vertigo
- ☐ Nose bleeds
- ☐ Polyps
- ☐ Problems smelling
- ☐ Post nasal discharge
- ☐ Nasal congestion
- ☐ Nasal discharge
- ☐ Sinusitis
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Gum disease
- ☐ Mouth sores
- ☐ Problems swallowing
- ☐ Goiter
- ☐ Diminished neck movement
- ☐ Problems tasting
- ☐ Cavities

Cardiovascular

- ☐ Murmurs
- ☐ Palpitations
- ☐ Heart attack history
- ☐ Arrhythmias
- ☐ Angina
- ☐ TIA
- ☐ Stroke
- ☐ Chest pain
- ☐ Congestive heart failure
- ☐ Blue hands/feet
- ☐ Rheumatic fever history
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Varicose veins
- ☐ Leg cramps

Date of last ECG (if any): ______________________

Respiratory

- ☐ Asthma
- ☐ Tuberculosis
- ☐ Bronchitis
- ☐ Cough
- ☐ Wheezing
- ☐ Emphysema
- ☐ Pneumonia history
- ☐ Shortness of breath when sitting or lying down
- ☐ Shortness of breath with exertion
- ☐ Pain with breathing

Date of last chest x-ray (if any): ____________________

Gastrointestinal

- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Food intolerance
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Peptic ulcer history
- ☐ Hemorrhoids
- ☐ Gas/bloating
- ☐ Nausea
- ☐ Vomiting
- ☐ Liver disease
- ☐ Hernias
- ☐ Fatty meals bothering
- ☐ Rectal bleeding/burning/itchi ng

How often do you have a bowel movement? ____________________

Date of last colonoscopy (if any): ____________________

Urinary Tract

- ☐ Incontinence
- ☐ Kidney stone history
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Pain with urination
- ☐ Waking to urinate

Musculoskeletal

- ☐ Muscle weakness
- ☐ Muscle aches
- ☐ Tremors
- ☐ Arthritis
- ☐ Stiffness
- ☐ Past injury

Skin/Integumentary

- ☐ Acne
- ☐ Dry skin
- ☐ Rash
- ☐ Hives
- ☐ Dandruff
- ☐ Har/nail changes
- ☐ Psoriasis
- ☐ Itchy skin
- ☐ Rosacea
- ☐ Eczema
- ☐ Skin cancer history
- ☐ Warts
- ☐ Hair loss

Neurological

- ☐ Paralysis
- ☐ Sciatica
- ☐ Seizures
- ☐ Headaches
- ☐ Migraines
- ☐ Numbness/tingling
- ☐ Carpal tunnel
- ☐ Fainting
- ☐ Dizziness/lightheaded ness

Mental/Emotional

- ☐ Anxiety
- ☐ Depression
- ☐ Fear/panic
- ☐ Eating disorder history
- ☐ Anger/irritability
- ☐ Suicidal thoughts
- ☐ Psychiatric hospitalization

Endocrine

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Mood swings
- ☐ Snacking often
- ☐ Hormone therapy
- ☐ Increased urination
- ☐ Increased thirst
- ☐ Hot/cold intolerance
- ☐ Needing to eat regularly
- ☐ Change in glove/shoe size

Hematologist/Lymphatic

- ☐ Anemia
- ☐ Easy bruising
- ☐ Swollen lymph nodes
- ☐ Circulation issues
- ☐ Fragile/sensitive skin
- ☐ History of a blood clot

FEMALE REPRODUCTIVE

Age of first menses? ______

Age of last menses? (if menopausal) ______

Length of cycle (in days) ______

Duration of menses (in days) ______

Number of pas/tampons used on your heaviest day? If you use a menstrual cup or disc, how often do you have to empty them?

Do you experience any of the following before or during your menses?

- ☐ Menstrual cramping
- ☐ Fatigue during menses
- ☐ Backaches during menses
- ☐ Breast tenderness or swelling
- ☐ Diarrhea
- ☐ Bloating
- ☐ Food cravings
- ☐ Mood changes
- ☐ Heavy bleeding
- ☐ Acne

BREAST HEALTH

Do you do breast self-exams monthly? ☐ Yes ☐ No

Do you know how to preform a self breast exam? ☐ Yes ☐ No

Do you have any of the following breast symptoms?

- ☐ Breast pain
- ☐ Breast discharge
- ☐ Breast mass
- ☐ Skin changes on the breast

Date of last mammogram (if any): ______

GYNECOLOGY AND PAP HISTORY

Date of last Pap smear exam and result:

History of an abnormal PAP? ☐ Yes ☐ No

Check all pelvic disease conditions that you have a history of:

- ☐ Ovarian cysts
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Ectopic pregnancy
- ☐ Ovarian/uterine disease
- ☐ Pelvic inflammatory disease
- ☐ History of a gynecological surgery or procedure

Check all pelvic symptoms you currently experience:
☐ Vaginal itching ☐ Vaginal odor ☐ Pelvic pain
☐ Pain with intercourse ☐ Abnormal vaginal discharge ☐ Skin changes or rashes

Are you sexually active? ☐ Yes ☐ No ☐ In Past

Sexual orientation? ____________________

Please indicate birth control or other hormones previously or currently used:

Current number of sexual partners (if any): ____________________

Do you experience any of the following: ☐ Low libido ☐ Bleeding after intercourse

Do you have a history of a sexually transmitted infection/disease? ☐ Yes ☐ No

PREGNANCY HISTORY

Number of pregnancies? ____________________

Number of live births? ____________________

Number of miscarriages? ____________________

Number of abortions? ____________________

Any complications with pregnancy or conception? ☐ Yes ☐ No

MENOPAUSE

Age at menopause: ____________________

Surgically induced menopause: ☐ Total hysterectomy ☐ Partial hysterectomy

Check all the symptoms you experience:
☐ Hot flashes ☐ Night sweats ☐ Vaginal dryness
☐ Decreased libido ☐ Palpitations ☐ Mood changes
☐ Incontinence ☐ Joint pain ☐ Sleep disruption
☐ Decreased memory or brain fog

Date of last DEXA/bone scan (if any): ____________________

MALE REPRODUCTIVE

Prostate/urinary symptoms?	☐ BPH ☐ Prostate cancer history	☐ Nocturia ☐ Incomplete urination	☐ Prostatitis ☐ Dribbling of urine ☐ Difficulty initiating urination
Do you preform monthly testicular exams?	☐ Yes ☐ No		
Date of last PSA (if any):	______________		
Date of last probate exam (digital rectal exam):	______________		
Check all the pelvic symptoms:	☐ Testicular pain ☐ Penial discharge ☐ Prostate disease	☐ Testicular swelling ☐ Impotency ☐ Rashes or skin changes	☐ Hernia ☐ Decreased libido
Are you sexually active?	☐ Yes	☐ No	☐ In Past
Sexual orientation?	______________		
Do you have a history of a sexually transmitted infection/disease?	☐ Yes ☐ No		
Please indicate hormones previously or currently used:	______________		
Do you experience any of the following?	☐ Low libido ☐ Fertility challenges	☐ Difficulty achieving an erection	☐ Difficulty maintaining an erection