TRUE HEALTH INTEGRATIVE MEDICAL CENTER

Dr. Adrienne Wilson, NMD
4525 S. Lakeshore Dr. #103, Tempe AZ, 85282
Tel: 480-779-0873

CONFIDENTIAL PATIENT INFORMATION (ADULT)

DATE:_____

Patient's Name:_____ Age:_____ Sex:_____ Birth date:_____

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

Phone (home):_____ (cell):_____ E-mail:_____

Emergency contact:_____ Relationship:_____ Phone:_____

Your Primary Care Physician:_____ Phone:_____ Fax:_____

Would you like Dr. Wilson to be your Primary Care Physician? ☐ Yes ☐ No ☐ Undecided

How did you hear about Dr. Wilson?_____

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PLEASE LIST THE HEALTH CONCERNS THAT BRING YOU IN TODAY

1.

2.

3.

How willing are you to change your lifestyle habits to improve your health? Unwilling- 0 1 2 3 4 5 -Very

	now	past	frequency	type
Antacids	____	____	_____	
Antibiotics	____	____	_____	
Antihistamines	____	____	_____	
Cough Suppressants	____	____	_____	
Decongestants	____	____	_____	
Laxatives	____	____	_____	
Pain Relievers	____	____	_____	
Other:	____	____	_____	

Please list all prescription medications and dosages: _____

_____

_____

Please list all vitamins, herbs, homeopathic, or other supplements that you are taking:_____

_____

ALLERGIES (to medications, supplements, foods, or environment):_____

_____

PAST SURGERIES/HOSPITALIZATIONS

Please list dates and reason for any surgeries or hospitalizations:

_____

_____

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HEALTH HISTORY

Please put an N if you have the condition now; P for in the past; B for both:

___ Measles	___ Scarlet Fever	___ Angina
___ Mumps	___ Rheumatism	___ Heart Murmur
___ Influenza	___ Bronchitis	___ Fatigue
___ Mononucleosis	___ Herpes (oral)	___ Muscle Weakness
___ Hay Fever	___ Herpes (genital)	___ Diarrhea
___ Headaches	___ Shingles	___ Constipation
___ Dizziness	___ Gonorrhea	___ Cough/Wheezing
___ Hives	___ Insomnia	___ Indigestion /Gas
___ Pneumonia	___ Jaundice	___ Anxiety
___ Colitis	___ Ringing in the Ears	___ Backaches
___ Joint Pain	___ Bladder Infection	___ Strep Throat
___ Frequent Infections	___ Memory Loss	___ Moodiness
Other:_____		___

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FAMILY HISTORY

Please check Self if you have had any of the following. Also, please identify any family member(s) that have had any of the following:

	Self	Family Member(s)
Alcoholism	___	_____
Heart Arrhythmia	___	_____
Autoimmune Disorder	___	_____
Bleeding Disorder	___	_____
Cancer	___	_____
Diabetes	___	_____
Epilepsy	___	_____
Heart Disease	___	_____
Other:_____	___	_____

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HEALTH & LIFESTYLE HABITS

Do you use tobacco? _____ If yes, how much per day? _____ For how long? _____

How often do you drink wine? _____ beer? _____ other alcohol? _____

How often do you drink caffeine? _____water?_____

How often do you exercise? _____ Form(s) of exercise _____

List any environmental chemicals, fumes, dust, etc. that you are/were repeatedly exposed to: _____

_____

Signature:_____ **Date:**_____