Life Long Care
of New London, PLLC

Amanda Hegnauer, ND

New Patient Intake Form

Name_____Date_____

Date of Birth_____ Age_____ Height _____Weight_____

Present Health Care Concerns: In your opinion, what are your most important health care concerns in their order of significance? Please indicate the concern that motivated you to come in today.

1)_____
2)_____
3)_____
4)_____

Health History: Mark all the sections that apply.

Health as a child? _____ Good _____ Fair _____ Poor
Childhood Illnesses? ____Scarlet Fever_____German Measles_____Measles _____Pertussis
_____Mononucleosis _____Polio _____Diabetes _____Rheumatic Fever _____Chicken Pox
_____Diptheria _____Mumps _____Whooping Cough
_____Other
_____

Were you breastfed as an infant? Y_____ N _____
Hospitalizations (year and reason)
_____
Surgeries (year and reason)
_____
Serious illness or injury (year and cause)
_____
Vaccinations (year, type, adverse reaction?)
_____

Medications: Include all supplements, prescription and non-prescription drugs and indicate name, dosage, how often taken and for how long:

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

Allergies: List any allergies you have to:

Drugs_____

Foods_____

Environmental_____

Animals_____

Other_____

What happens when you have an allergy attack?_____
_____

Habits: Substance use: For each please include approximate amount and for how long. If you have quit, please indicate past amount, duration of usage and when stopped.
Alcohol: _____Y _____ N _____
Tobacco: _____Y _____ N _____
Caffeine: _____ Y _____ N _____
Recreational Drugs: _____ Y _____ N _____

Diet: Any dietary restrictions or regimen? Describe
_____
Are you satisfied with your diet now? Do you eat three meals a day?
_____
Do you have any food cravings? What are they?

Do you sleep well? _____ Wake rested? _____ Average hours of sleep? _____
Enjoy your work? _____ Spend time outside? _____
How much time? _____ Exercise regularly? _____
What type of exercise? _____
How often? _____ How long? _____

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Personal History: Currently (place a "C") or in the past (place a "P)

Abuse _____
Skin Disease _____
Heart Disease _____
Arthritis _____
Stomach/Intestinal Disorder _____
Hypertension _____
Chronic Constipation _____
Contemplated Suicide _____
Physical Trauma _____

Headaches _____
Allergies _____
Shortness of Breath_____
Hepatitis _____
Back Injury _____
Tested Positive for HIV/AIDS _____
Chronic Diarrhea ____
Depression _____
Sexually transmitted Infection _____

For Women:

Age of onset of Menses: _____ Frequency of Menses:_____
Flow: (circle one) Heavy Moderate Light
Pain with Menses: (circle one) Severe Moderate Light None
Date of last period: _____ Date of last Pap Smear: _____
Any history of abnormal Paps: (if yes please specify results, treatments and dates)

_____
Are you sexually active? _____ Do you need help with birth control? _____
Type of Birth Control method used (if relevant) _____
Do you practice safe sex?_____
Pregnancies: _____ none _____ full-term _____ premature _____ miscarriages _____ abortions
Infertility? If yes, any work-ups, results and dates:_____
_____
_____

Vaginal Infections? Current, past, and type of symptoms:_____
_____
Any PMS? If yes, timing of symptoms in relation to your menses and symptoms:
_____
Any history of DES exposure?
_____
Date of last mammogram and results:
_____
Date of menopause, if relevant:
_____
Any problems associated with menopause?
_____
_____

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For Men:
Date of last physical exam: _____
Date of last prostate exam: _____ Any concerns found? _____
Do you have any difficulty or pain with urination? _____
Do you ever have to get up at night to urinate? If so, how often? _____
Are you sexually active? _____ Do you practice safe sex? _____
Do you have any pain or difficulty with erection? _____ Ejaculation?
_____
Any history of male infertility? (If yes, please give diagnosis and treatments tried)
_____
_____

For Men And Women:
Family History: Has any blood relative (mother (M), father (F), brother (B), sister (S), grandmother (GM), grandfather (GF), aunt (A), uncle (U), had any of the following conditions, in the past or present? Please indicate if relative is maternal or paternal, (ie. MGM: maternal grandmother, PU: paternal uncle).

Condition	**Relative**	**Condition**	**Relative**
Anemia		Arthritis	
Asthma		Allergies	
Bleeding		Constipation	
Diabetes		Drugs/Alcohol	
Eczema		Genetic Disease	
Glaucoma		Herpes	
Headaches		Heart Problem	
Hypertension		Kidney Problem	
Liver Problem		Mental Disorder	
Osteoporosis		Seizure	
Sinus Problem		Stomach Problem	
Stroke		Thyroid Disease	
Tuberculosis		VeneralDisease	

Cancer (specify type)
_____
Other
_____

Relative	Heath Status If Deceased (cause of and age)	Age
Father		
Mother		
Siblings		

Additional Notes: