Seek Optimal Health, P.C.
805 Tuolumne Street,
Vallejo, CA 94590

2018 SOH Adult Health History (updated 1/2018)

Adult Intake Form

Contact Information

Personal Details

First Name *

Last Name *

Date of Birth * / / (MM/DD/YYYY)

Gender * ☐ Male ☐ Female

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker, current status unknown ☐ Unknown if ever smoked

Primary Contact Details

Caregiver First Name

Caregiver Last Name

Email *

Home Phone

Mobile Phone _____

Work Phone _____

Extn _____

Primary Phone ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 * _____

Address Line2 _____

City * _____

Country * _____

State * _____

Zip code * _____

Postbox No _____

Emergency Contact Name _____

Emergency Contact Number _____

Extn _____

Is it okay to leave a detailed message at your primary phone? * _____

Primary Insurance Details

Insurance Type * ☐ MEDICARE ☐ MEDICAID ☐ TRICARE CHAMPUS ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER _____

Insurance Plan Name or Program Name * _____

ID * _____

Insurance Company Name (Payer Name) * _____

Payer Id * _____

Payer Address _____

Payer City _____

Payer Country _____

Payer State _____

Payer ZipCode _____

Valid From / / (MM/DD/YYYY)

Valid Until / / (MM/DD/YYYY)

Payer ZipCode _____

Copay _____

Deductible _____

Employer/School Name _____

Comments _____

_____

_____

_____

Insured Person Details

Patient Relationship * ☐ Self ☐ Spouse ☐ Child ☐ Other

First Name * _____

Last Name * _____

Date of Birth * / / (MM/DD/YYYY)

Gender * ☐ Male ☐ Female

Address Line 1 _____

Address Line 2 _____

City _____

Country _____

State _____

Zip Code _____

Home Phone _____

Mobile Phone _____

Are you currently on medical disability? * ☐ Yes ☐ No

Do you receive any Medicare Benefits? * ☐ Yes ☐ No

Referral Source

Was there a specific referral that led you to schedule with one of the providers at Seek Optimal Health,P.C.? (please be specific: include name of website, friend, etc. if applicable)

Reason for Visit

Please list the main reasons for seeking care from the providers at Seek Optimal Health, P.C. (e.g. low energy, back pain, high blood pressure, headaches, PMS, etc.). *

Apart from your main reason for coming to us, are there any other health goals that you'd like us to work on? *

Complimentary Care Agreement

While the services offered at Seek Optimal Health, P.C. are meant to help you improve your overall health and well-being, they are not intended to take the place of a relationship with a primary care provider who offers standard recommended screening services (mammograms, pap smear, prostate exams, etc).
I understand that the care I receive from Seek Optimal Health, P.C. is considered complimentary.
I further understand that in order to receive care from the providers at Seek Optimal Health, P.C. I must maintain a relationship with a primary care physican of my choosing and that no physician at Seek Optimal Health, P.C. may function as my primary care physician. * ☐ Yes ☐ No

Other Healthcare Providers

Please provide the name and basic contact info for your primary care physician, as well as any other

providers who are significantly involved in your care at the current time. * _____

Symptom Review

Please let us know if you're currently having any of the symptoms listed below by answering yes or no:

General:

unexplained weight loss *	☐ Yes	☐ No
unexplained weight gain *	☐ Yes	☐ No
fever *	☐ Yes	☐ No
chills *	☐ Yes	☐ No
night sweats *	☐ Yes	☐ No
morning fatigue *	☐ Yes	☐ No
afternoon fatigue *	☐ Yes	☐ No
trouble falling asleep *	☐ Yes	☐ No
trouble staying asleep *	☐ Yes	☐ No

Eyes

recent significant vision changes *	☐ Yes	☐ No
blurred vision *	☐ Yes	☐ No
double vision *	☐ Yes	☐ No
eye pain *	☐ Yes	☐ No
itchy eyes *	☐ Yes	☐ No

Ears/Nose/Throat

ringing in ears (tinnitus) *	☐ Yes	☐ No
hearing changes *	☐ Yes	☐ No
post nasal drip *	☐ Yes	☐ No
mouth sores *	☐ Yes	☐ No
tooth pain *	☐ Yes	☐ No
hoarseness/loss of voice *	☐ Yes	☐ No

trouble swallowing *	☐ Yes	☐ No
abnormal tastes *	☐ Yes	☐ No
nosebleeds *	☐ Yes	☐ No

GI

appetite change *	☐ Yes	☐ No
bloating *	☐ Yes	☐ No
abdominal pain *	☐ Yes	☐ No
heartburn/indigestion *	☐ Yes	☐ No
constipation *	☐ Yes	☐ No
diarrhea *	☐ Yes	☐ No
nausea *	☐ Yes	☐ No
vomiting *	☐ Yes	☐ No
blood in stools *	☐ Yes	☐ No
yellowing of the skin *	☐ Yes	☐ No
food intolerances *	☐ Yes	☐ No
stomach ulcers *	☐ Yes	☐ No

Cardiovascular

irregular heartbeats/palpitations *	☐ Yes	☐ No
chest pain *	☐ Yes	☐ No
arm swelling *	☐ Yes	☐ No
leg swelling *	☐ Yes	☐ No
shortness of breath with low intensity activity *	☐ Yes	☐ No

Respiratory

productive cough *	☐ Yes	☐ No
dry cough *	☐ Yes	☐ No
shortness of breath at rest *	☐ Yes	☐ No
shortness of breath when lying flat *	☐ Yes	☐ No

pain with breathing *	☐ Yes	☐ No

Musculoskeletal

hip pain *	☐ Yes	☐ No
joint pain *	☐ Yes	☐ No
If you answered yes to having joint pain, which of the following is affected?	☐ hip ☐ wrist ☐ elbow ☐ ankle	☐ shoulder ☐ knee ☐ finger ☐ foot
neck pain *	☐ Yes	☐ No
upper back pain *	☐ Yes	☐ No
mid back pain *	☐ Yes	☐ No
low back pain *	☐ Yes	☐ No

Genitourinary

trouble emptying bladder *	☐ Yes	☐ No
pain with urination *	☐ Yes	☐ No
increased frequency or urgency *	☐ Yes	☐ No
frequent urination at night *	☐ Yes	☐ No
blood in the urine *	☐ Yes	☐ No
incontinence *	☐ Yes	☐ No
penile or vaginal discharge *	☐ Yes	☐ No
hernia *	☐ Yes	☐ No

Skin

dry skin *	☐ Yes	☐ No
rashes *	☐ Yes	☐ No
itching *	☐ Yes	☐ No
acne *	☐ Yes	☐ No
brittle nails *	☐ Yes	☐ No
thinning hair *	☐ Yes	☐ No

Endocrine

neck swelling *	☐ Yes	☐ No
excessive urination *	☐ Yes	☐ No
tremor *	☐ Yes	☐ No
heat intolerance *	☐ Yes	☐ No
cold intolerance *	☐ Yes	☐ No
excessive thirst or hunger *	☐ Yes	☐ No

Psychiatric

anxiety *	☐ Yes	☐ No
depression *	☐ Yes	☐ No
phobias *	☐ Yes	☐ No

Neurologic

fainting *	☐ Yes	☐ No
dizziness *	☐ Yes	☐ No
tingling *	☐ Yes	☐ No
numbness *	☐ Yes	☐ No
trouble coordinating movements *	☐ Yes	☐ No
changes to speech *	☐ Yes	☐ No
weakness *	☐ Yes	☐ No
dizziness *	☐ Yes	☐ No

Hematologic/Lymphatic

anemia *	☐ Yes	☐ No
bleeding tendency *	☐ Yes	☐ No
easy bruising *	☐ Yes	☐ No
swollen glands *	☐ Yes	☐ No

Allergic/Immune

history of Lyme disease *	☐ Yes	☐ No

history of severe allergic reactions * ☐ Yes ☐ No

hives * ☐ Yes ☐ No

hay fever * ☐ Yes ☐ No

history of autoimmune disease * ☐ Yes ☐ No

Menstrual History / Menopausal Symptoms (Females only)

Which of the following accurately describes your current menstrual status and cycle regularity?

☐ Pre-menopausal / regular cycles
☐ Pre-menopausal / irregular, frequent cycles
☐ Pre-menopausal / irregular, infrequent cycles
☐ Post-menopause / no cycles
☐ Others _____

When was your last menstrual period? _____

Have you had any of the following recently?

☐ Painful menstrual periods
☐ Difficulty conceiving
☐ Painful intercourse
☐ Vaginal discharge or itching
☐ Sexually transmitted infection
☐ Fibroids
☐ Endometriosis
☐ DES exposure
☐ PMS
☐ Others _____

If you have a history of premenstrual symptoms, please provide a list of your symptoms.

_____
_____
_____
_____

Personal Medical History

Please list any significant medical conditions that you have been diagnosed with / treated for. *

_____
_____
_____
_____

Please list any history of trauma (both physical and emotional incidents are pertinent). Please be sure to include any and all hospitalizations, surgeries, broken bones, major injuries, concussions, motor vehicle collisions, significant falls, etc. (Please provide dates if possible - estimate if necessary) *

_____
_____
_____
_____

Personal Birth History

Were you born vaginally (natural) or by c-section? _____

If you were born vaginally, was any assistance required (e.g. forceps or a vacuum)? _____

Was your mother "induced" to go into labor? ☐ Yes ☐ No

Did your mother receive an epidural? ☐ Yes ☐ No

Did your mother receive any oral pain medicines? ☐ Yes ☐ No

Were there any complications related to your birth that affected either you or your mother (deceleration, malnutrition, drug use, breach, twins, tearing, bleeding, etc.)? If yes, please provide any details available. _____

Personal Dental History

Do you currently have any Amalgam (Silver) fillings? * ☐ Yes ☐ No ☐ Not sure

Have you ever had a root canal (if yes how many and when)? * _____

Have you had any dental extractions (if yes how many and when)? * _____

Do you currently use any dental appliances (orthotics, splints, mouthguards, etc.)? * _____

Have you ever had braces (if yes for how long)? * _____

Have you ever used a rapid palate expander? * _____

Do you have any permanent or fixed bridges or retainers? * ☐ Yes ☐ No

Have you had any dental implants? * ☐ Yes ☐ No

Do you have any TMJ (jaw joint) pain or dysfunction? * ☐ Yes ☐ No

Do you receive regular dental exams / cleanings? * ☐ Always ☐ Usually ☐ Never

Current Medications

Please list all prescription medications you are taking (MEDICATION, DOSE, REASON). Please state "none" if you are not on any medications. *

Current Nutritional Supplements

Please list all vitamins and herbal supplements you are taking (BRAND & PRODUCT, DOSE, REASON). Please state "none" if you are not on any supplements. *

Allergies

Do you have any known drug allergies? * ☐ Yes ☐ No

Do you have any known food allergies? * ☐ Yes ☐ No

Do you have any known environmental allergies? * ☐ Yes ☐ No

If you answered yes to any of the above, please list all specific allergens along with reactions and severity (1-3 with 3 being worst).

Social History

Occupation (Current/Former): *

Employer:

Who do you live with?

☐ spouse ☐ partner
☐ relatives ☐ parents
☐ friends ☐ alone
☐ children ☐ pets
☐ Others _____

Do you have any children? If so, what are their ages?

Do you work in a profession, or live in an area where

you've had long term exposure to chemicals or mold? If so, please explain. *

Current birth control method:

Past pregnancy complications / difficulty conceiving?

Do you exercise? If so, what kind and how often? *

Do you participate in any sports? If yes, what kind?

Please list any major sources of stress in your life. *

How do you handle stress?

Diet

Dietary preferences/restrictions *

Describe what you ate for BREAKFAST the last 3 days (list as day 1, 2, 3). If you can't remember, list what is typical. *

Describe what you ate for LUNCH the last 3 days (list

as day 1, 2, 3). If you can't remember, list what is typical. *

Describe what you ate for DINNER the last 3 days (list as day 1, 2, 3). If you can't remember, list what is typical. *

Describe what beverages you DRINK throughout the course of a typical week *

Describe what you eat as SNACKS throughout the typical week *

Do you eat fish? What kind and how often?

Do you drink any alcoholic beverages? If yes, how much and how often? *

Do you consume caffeinated beverages? If yes, how much, what kind, and how often? *

Family History

Mother :

Is your mother living? If so, what is her current age? If deceased, what was the age of death? Does/did she have any significant medical conditions? *

Father :

Is your father living? If so, what is his current age? If deceased, what was the age of death? Does/did he have any significant medical conditions? *

Sister(s) :

Please list age(s) of all sisters, whether they are living or deceased, and any significant medical diagnoses any of them have. *

Brother(s) :

Please list age(s) of all sisters, whether they are living or deceased, and any significant medical diagnoses any of them have. *

Maternal Grandmother :

Is your maternal grandmother living? If so, what is her current age? If deceased, what was the age of death? Does/did she have any significant medical conditions?

Paternal Grandmother :

Is your paternal grandmother living? If so, what is her current age? If deceased, what was the age of death? Does/did she have any significant medical conditions?

Maternal Grandfather :

Is your maternal grandfather living? If so, what is his current age? If deceased, what was the age of death? Does/did he have any significant medical conditions?

Paternal Grandfather :

Is your paternal grandfather living? If so, what is his current age? If deceased, what was the age of death? Does/did he have any significant medical conditions?

Other

Please send us any pertinent recent labs and/or imaging studies via the patient health portal.