Dr. Kara Lolley & Associates
Manage your health naturally

Confidential Health Intake Form

Name: _____ **Date:** _____

Occupation: _____

Name of Primary Care Physician: _____

What are your most important health concerns? List in order of importance**:**

_____

_____

_____

Please list all current medications and supplements:

_____

_____

_____

_____

_____

Childhood Illnesses:

Mumps ___ Measles ___ Chickenpox __ German Measles ___ Rheumatic fever ___ Diphtheria ___

Other_____

_____

Significant trauma (falls, injuries, auto accidents):

_____

_____

_____

_____

Surgeries and Hospitalizations:

_____

_____

_____

_____

CONTINUED ON THE NEXT PAGE

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Confidential Health Intake Form (continued)

Family History: (please indicate member and (F) for father's side or (M) for mother's side.)

Cancer ____ Diabetes _____ Heart Disease ____ High Blood Pressure _____ Stroke_____ Seizures ___

Asthma/Hives/Hay fever ____ Anemia ___ Kidney Disease _____ Tuberculosis (TB) _____

Depression _____ Schizophrenia _____ Dementia ____

Other_____

_____

Describe any known reactions or allergies to foods/drugs/environmental factors: _____

_____

_____

_____

Describe your exercise habits: _____

_____

_____

Describe your sleep habits: _____

_____

Do you wake feeling rested? _____ How long does it take you to fall asleep? _____

What is your current height and weight? _____

Date of last: Screening blood work _____ Colonoscopy _____

<u>Females Only:</u>

Age of first menses: _____ Duration of menses: _____

Length of cycle: _____

Date of last PAP: _____

Have you ever had an abnormal PAP? If yes, when? _____

Date of last mammogram: _____

Have you ever had an abnormal mammogram? If yes, when? _____