General Health and Skin History Intake Form

Thank you for taking the time to fill out this form. Please be as thorough as possible. If you do not know the answer to a question you can leave blank. We will discuss this in detail at your first visit. Please note all information on this form is strictly confidential.

Patient Name: _____ Today's Date: _____

Personal Information

Gender _____ Age _____ DOB _____ Marital Status_____

Spouse/Partner Name _____ How long have you been together? _____

Do you have children? _____ If yes, how many and what are their ages? _____

How would you describe your relationship with your partner? _____

With your children? _____

Close friends? _____

Employment

Occupation: _____ Employer _____

Work schedule and average hours per week? _____

How long have you been at this job? _____ Do you like your job? _____

Do you feel fulfillment with the work you do? Please describe?

_____

_____

Hobbies/Interests

Other than work and family, how do you spend your time? _____

What do you do for fun? _____

What activities bring you joy? _____

Are you actively learning anything new or taking classes? _____

Skin Concerns/Goals

Skin condition: _____

What areas are affected? _____

When did it start? _____

Has it ever been biopsied? _____ If yes, what did it show? _____

Please provide a copy of pathology report if possible.

Is it getting better, worse, or about the same? _____

Does anyone else in your family have this problem or other skin problems? _____

Do you have a skincare routine? If yes, please describe? _____

_____

Do you use make-up, body washes, perfumes or other sprays etc.)

_____

Prior treatments? Please list both OTC and prescription and how long they were tried:

1.

2.

3.

4.

5.

Has anything helped?

_____

Health History

Current Weight: _____ Any recent weight gain/loss (>10lbs)? _____

Height: _____ Do you see PCP regularly? _____

Primary Care Physician Name, Address, and Phone Number:

_____

Other medical providers you see regularly? Please list name and specialty:

_____

Review of Systems: Circle any that you have experienced.

General
Activity change
Fatigue
Weight change
Cold extremities
Poor sleep
Excessive sweating

Neurological
Headaches/Migraines
Head trauma
Dizziness
Vertigo
Poor concentration
Confusion
Memory loss
Numbness/tingling
Spasms/tremors
Seizures

Ear, Nose and Throat
Ear pain
Ears ringing
Ear infections
Hearing loss
Congestion
Itchy or runny nose
Nose bleeds
Sinus pressure
Loss of smell
Post nasal drip
Dry/itchy mouth
Itchy mouth
Mouth sores
Bad breath
Frequent sore throat
Difficulty swallowing
Loss of taste
Hoarseness
Snoring
Breaths through mouth
Inflamed/bleeding gums
Cavities
Tooth sensitivity
Neck pain
Swollen glands

Eyes
Dry/watery/itchy eyes
Eye pain
Blurred vision
Double vision
Eye discharge
Floaters
Sensitivity to light
Poor night vision
Styes/eye cysts
Cataracts
Vision loss

Endocrine
Thyroid issues
Heat or cold intolerance
Excessive thirst
Excessive hunger
Diabetes
Poor appetite

Immune
Slow wound healing
Chronic infections
Reactions to vaccinations
Allergies

Respiratory
Asthma/wheezing
Allergies
Sleep apnea
Shortness of breath
Chronic cough
History of smoking or 2nd hand exposure

Skin & Hair
Dry skin
Itchy skin/scalp
Hair loss
Easy bruising
Unspecified rashes
Hives
Acne
Eczema
Psoriasis
Shingles
Ringworm
Bumps on back of arms
Moles
Spider/varicose veins
Nail changes
Pigment changes
Sun sensitivity

Cardiovascular
Chest pain
Heart racing/Palpitations
Leg/ankle swelling
Dizziness on standing
Heaviness in legs
Exhaustion with minor exertion

Musculoskeletal
Back pain/stiffness
Bone pain
Gait issues
Joint pain/stiffness
Muscle cramps/spasms

Tight muscles
Swollen joints
Chronic pain
Loss of height

Psychological
Agitation
Depression
Mood swings
Hyperactive
Anxiety

Gastrointestinal
Changes in appetite
Abdominal pain/bloating
Gas/flatulence
Nausea/vomiting
Heartburn
Constipation (<1 stool/day)
Stool hard to pass
Loose stools/diarrhea
Blood/black tarry stool
Mucous in stool
Undigested food in stool
Ulcers
Hemorrhoids
Food sensitivity

Urinary
Frequent urination
Difficult or painful urination
Incontinence
Blood in urine
Chronic UTIs
Kidney infections
Bladder infections

Past Medical History

Please list conditions you have been diagnosed with and treatment:

1._____

2._____

3._____

4._____

5._____

Please list all surgeries and hospitalizations:

_____

_____

_____

Please list all known allergies and reaction:

_____

_____

_____

How many times have you been treated with antibiotics in your lifetime? _____

Have you ever been on long-term antibiotic therapy? _____

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Do you take probiotics or did you while being treated with antibiotics? _____

Do you consume fermented foods such as yogurt, kefir, kombucha, and or/sauerkraut? _____

Please list all current supplements (vitamins, minerals, herbs, homeopathic remedies)

_____

_____

_____

Please list all current medications (prescription and over-the-counter)

_____

_____

_____

Childhood Health History

Mom's health prior to giving birth to you? _____

Birth details? Premature or full-term, vaginal or C-section, bottle or breast-fed?

_____

Were you sedentary or active as a child?_____

Did you eat candy/sugar/soda? How often? _____

General childhood health? _____

Have you had all childhood vaccinations? _____

Have you ever had an adverse reaction to a vaccine? _____

Dental Health

How often do you visit the dentist? _____ Date of last visit? _____

Do you brush your teeth regularly? _____ Floss? _____

Do you have fillings and if so are they silver, gold, or other material? _____

Dental Surgeries? _____ Overall dental health? _____

Gastrointestinal Health

Do you feel like you digest your food well? _____ Are you a slow or fast eater? _____

Do you have bloating, indigestion/heartburn, abdominal pain, diarrhea, or constipation after meals? _____

How often do you have a bowel movement? _____

Stool consistency? _____ Are bowel movements easy to pass? _____

How many times a day do you urinate? _____ Is urine clear or yellow? _____

Family History

Please indicate if any family members have had any of the following:

Acne _____ Rosacea _____

Eczema _____ Psoriasis _____

Skin cancer _____ Other cancer _____

Autoimmune condition _____ Allergies _____

Asthma _____ Diabetes _____

Kidney Disease _____ Osteoporosis _____

Thyroid condition _____ Other medical illness _____

Testing

Please submit any diagnostic test results you have had in the last year. Can e-mail to ckylemd@outlook.com or mail to 247 Main Street S/Woodbury, CT 06798.

For Women

Age of first menstrual cycle? _____ # of pregnancies: _____ # of live births: _____

Are your cycles regular? _____ Length of typical cycle? _____ Date of LMP: _____

Length of bleeding (days): _____ Heavy, moderate or light? _____ PMS? _____

Please circle PMS symptoms: Cravings Bloating Breast tenderness Moodiness Cramps Irritability Tendency to cry Lower back pain Fatigue

Date of last PAP test: _____ Any History of irregular PAPs? _____

Do you see GYN regularly? _____ Do you take hormone therapy? _____

Have you had mammogram, therma scan, or bone density scan in past? _____

For Men

Do you see a PCP regularly? _____ Do you have regular prostate exams? _____

Have you had testosterone levels checked? _____ If yes, have they been normal? _____

Are you on any testosterone or other hormonal supplementation? _____

Lifestyle

Stress. Rate level 1-10 _____

List major stressors: _____

How do you manage stress? _____

Do you consider yourself happy overall? _____

Exercise? Yes/no? _____ Frequency? _____ Intensity? _____

Describe exercise activities? _____

Do you enjoy your exercise routine? _____ Are you an active person overall? _____

Sleep. How many hours per night? _____ Do you feel well-rested in the morning? _____

What time do you usually go to bed and wake up? _____ Do you nap? _____

Do you wake up during the night? _____ if yes, how many times? _____

Caffeine/Alcohol/Tobacco/Drugs. Yes/no? _____

If yes, please detail type and frequency? _____

_____

Environmental exposures.

What type of personal care products do you use (Deodorant/soap/shampoo/detergents etc)?

_____

Do you use a cell phone? _____ If yes, where do you keep it? _____

Do you have a pet or other farm animals? _____

How much time do you spend outdoors? _____

Do you light scented candles or use air fresheners? _____

What kind of home cleaning supplies do you use? _____

Do you eat organic food? _____ If yes, what percentage? _____

Do you eat canned food? _____ If yes, how often? _____

Drink bottled water, tap, or filtered? _____ Other drinks you consume regularly

What kind of cookware and food storage containers do you use? _____

Damp or moldy home or workplace? _____

Any workplace chemicals/solvents/exposures? _____

Eating habits. Are you currently dieting (if yes, is it working?) _____

Do you have or have you ever been diagnosed with an eating disorder? _____

Do you enjoy cooking? _____ Do you enjoy grocery shopping? _____

How often do you cook full meals at home? _____

Are there any foods you do not eat and if so, what are the reasons? _____

How often do you eat fruits? _____ Vegetables? _____

How often do you eat out (including take-out)? _____

Do you typically eat alone, with others, in car, in front of tv, while working? (circle)

What types of beverages do you usually drink? _____

How many meals do you eat per day? _____ Do you skip any intentionally? _____

What times do you typically eat your meals? _____

Are you satisfied after your meals? _____

Do you snack? _____ Food cravings? _____

Adverse reactions to certain foods? _____ If yes, please describe _____

_____

Do you notice any particular foods cause skin breakouts or irritation? _____

*Please also complete separate three-day diet recall form.