Dr. Jessica Kooima, PLLC
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Date:

Patient Name:_____

Age:_____ Date of Birth:_____ Height:_____ Weight:_____

Gender:_____ Marital Status: Married/Single/Divorced/Widowed Children:_____

Occupation:_____ Employer:_____

Highest level of education:_____

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

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-mail:_____

Person to Contact in Case of Emergency:_____

Relationship to Patient:_____ Phone:_____

How did you hear about us?
_____Internet Search
_____Website
_____Referred by Practitioner? Who_____
_____Current Patient? Who_____
_____Other? _____

Insurance Company:_____
Primary Care Doctor:_____
Pharmacy (if use specific pharmacy regularly)_____

If patient is a minor, name of Parent/Guardian (s)

HEALTH CONCERNS

Please list your current health concerns in order from most bothersome to least bothersome. Please include mental, emotional, spiritual, and physical concerns:

1._____
2._____
3._____
4._____
5._____
6._____

Hospitalizations/Surgeries/Major Illnesses

	Date	Condition/Procedures
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Xrays/Ultrasounds/CT Scans/MRIs/Other Imaging

1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

ALLERGIES

Please list any medications, food, environmental or miscellaneous allergies:

_____

MEDICATIONS

Please include prescription and over the counter:

	Medication	Dosage/Frequency	Condition Treated
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

SUPPLEMENTS

	Supplement/Brand	Dosage/Frequency	Condition Treated
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Family History Father, Mother, Child, Sibling, Maternal/Paternal Grandparents						
	F	M	C	S	MG	PG
Alcoholism						
Allergies						
Alzheimer's Dz						
Anemia/Clotting Disorder						
Anxiety Disorder						
Arthritis						
Asthma						
Birth Defect						
Cancer:_____						
Cancer:_____						
Cancer:_____						
Depression						
Bipolar						
Diabetes						
Epilepsy/Seizures						
Gallbladder Dz						
Heart Attack						
High Cholesterol						
High Blood Pressure						
Hypoglycemia						
Kidney Dz						
Liver Dz						
Migraines						
Stroke						
Thyroid Dz						
Tuberculosis						
Other:						

Social History	
Exercise: Type/Frequency/Minutes	
Water intake: oz/day	
Coffee/Tea: oz/day	
Soda: oz/day	
Alcohol: oz/day/week/mos	
Cigarettes/Chewing pk/day yrs?	
Recreational Drug Use:	Type:

What are your greatest sources of stress?	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____
What do you do to relieve stress?	_____ _____ _____ _____ _____
Do you have an active spiritual practice?	_____ _____ _____ _____ _____ _____ _____

PAST MEDICAL CONDITIONS

Please check any conditions in your history

	ADD/ADHD		Chemical Dependency		HIV Positive		Prostate Problems
	AIDS		Chicken Pox		Kidney Disease		Psoriasis/Eczema
	Alcoholism/Addiction		Depression/Anxiety		Leg Cramps		Psychiatric Care
	Allergies		Diabetes		Liver Disease		Rheumatic Fever
	Anemia		Emphysema		Lyme Disease		Scarlet Fever
	Anorexia		Epilepsy		Measles		Sexual Abuse
	Appendicitis		Gall Bladder Disease		Migraine Headaches		Stroke
	Arthritis		Glaucoma		Miscarriage		Suicide Attempt
	Asthma		Goiter		Mononucleosis		Thyroid Condition
	Bipolar		Gonorrhea		Multiple Sclerosis		Tonsillitis
	Bleeding Disorder		Gout		Mumps		Tuberculosis
	Breast Lump		Heart Disease		Pacemaker		Typhoid Fever
	Bronchitis		Hernia		Physical Abuse		Ulcers
	Bulimia		Herpes (Oral/Genital)		Pneumonia		Vaginal Infections
	Cancer:_____		High Cholesterol		Polio		Venereal Disease
	Cataracts		Mental/Emotional Abuse		Physical Abuse		

VACCINATIONS: D=Disease, I=Immunized, N=Neither

Measles: D I N Chicken Pox: D I N Mumps: D I N Hepatitis A: D I N
Tetanus: D I N Pertussis/WC: D I N Flu: D I N Hepatitis B: D I N
German Measles/Rubella: D I N Hepatitis C: D I N
Vaccination Reactions:_____

Review of Systems

Present weight:_____lbs Weight one month ago:_____lbs Weight one year ago:_____lbs
Height:_____feet _____in
Ideal weight:_____lbs
Good Energy: Y N P Fatigue: Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst_____
If you have fatigue can you do what you need to during the day? Y N
How many hours of sleep per night? _____ What time go to bed? _____ What time do you wake?___
If you wake up, what is the reason? _____
Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P
Sleep walk: Y N P Grind Teeth: Y N P Snore: Y N P

SKIN

Rash:	Y N P	**Color Change:**	Y N P
Hives:	Y N P	**Lump:**	Y N P
Psoriasis/eczema:	Y N P	**Itchy:**	Y N P
Dry:	Y N P	**Warts/moles:**	Y N P
Cancer of the skin:	Y N P	**Perspiration:**	Y N P

HEAD

Headaches:	Y N P	**Migraine:**	Y N P
Dandruff:	Y N P	**Head Injury:**	Y N P
Oily Hair:	Y N P	**Hair Loss:**	Y N P
Dry Hair:	Y N P		

EYES

Dry:	Y N P	**Blurry Vision:**	Y N P
Watery:	Y N P	**Cataracts:**	Y N P
Double Vision:	Y N P	**Styes:**	Y N P
Glaucoma:	Y N P	**Discharge:**	Y N P
Strain:	Y N P	**Dark Under Eyelid:**	Y N P
Itchy:	Y N P		

EARS

Diminished Hearing:	Y N P	**Ringing in Ears:**	Y N P
Infections:	Y N P	**Pain:**	Y N P

NOSE

Frequent Colds:	Y N P	**Nosebleeds:**	Y N P
Congestion:	Y N P	**Post Nasal Drip:**	Y N P
Polyps:	Y N P	**Seasonal Allergies:**	Y N P

MOUTH/THROAT

Canker Sores:	Y N P	**Cold Sore:**	Y N P
Sore Throat:	Y N P	**Gum Disease:**	Y N P
Dentures:	Y N P	**Cavities:**	Y N P
Loss of taste:	Y N P	**Hoarseness:**	Y N P

NECK

Stiffness:	Y N P	**Swollen Glands:**	Y N P
Full Movement:	Y N P	**Tension:**	Y N P

RESPIRATORY

Cough:	Y N P	**TB:**	Y N P
Shortness of Breath:		**Bronchitis:**	Y N P
W/ Exertion	Y N P	**Pneumonia:**	Y N P
Sitting	Y N P	**Painful Breathing:**	Y N P
Lying down	Y N P	**Asthma:**	Y N P
Wheezing:	Y N P		

CARDIOVASCULAR

High Blood Pressure:	Y N P	**Rheumatic Fever:**	Y N P
Low Blood Pressure:	Y N P	**Murmurs:**	Y N P
Arrhythmias:	Y N P	**Palpitations:**	Y N P
Edema:	Y N P	**Chest Pain:**	Y N P

URINARY TRACT

Incontinence:	Y N P	**Pain w/ urination:**	Y N P
Frequent Infections:	Y N P	**Kidney Stones:**	Y N P
Urgency:	Y N P	**Discharge/Blood:**	Y N P

GASTROINTESTINAL

Heartburn:	Y N P	**Bowel Movement:** (# of time per day)	_____
Indigestion:	Y N P	**Recent BM Change**:	Y N P
Bloating:	Y N P	**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P	**Hemorrhoids:**	Y N P
Vomiting:	Y N P	**Gall Bladder Disease:**	Y N P
Change in Appetite:	Y N P	**Liver Disease:**	Y N P
Pancreatitis:	Y N P	**Ulcer:**	Y N P

MUSCULOSKELETAL

Weakness:	Y N P	**Arthritis:**	Y N P
Stiffness:	Y N P	**Leg Cramps:**	Y N P
Tremors:	Y N P	**Pain:**	Y N P

NERVOUS SYSTEM

Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P

MALE GENITALIA

Testicular Pain/swelling:	Y N P	**Sexually Active:**	Y N P
Hernia:	Y N P	**S.T.D.:**	Y N P
Discharge:	Y N P	**Prostate Disease Symptoms:**	Y N P
Impotence:	Y N P	**Sexual Orientation:**	_____

FEMALE GENITALIA

Age Period Began:	_____	**How often period occurs:**	_____
How long period lasts:	_____	**Heavy menstrual bleeding:**	_____
Menstrual cramping PMS:	Y N P	**Menstrual Pain:**	Y N P
Times Pregnant:	_____	**Food cravings:**	Y N P
Miscarriages:	_____	**How many births:**	_____
Abortions:	_____	**Sexually Active:**	Y N P

FEMALE GENITALIA (continued)

Any abnormal paps: Y N P
Date: _____
If menopausal since what age: ____
Dryness: Y N P
Pain w/ Intercourse: Y N P
S.T.D.: Y N P
Sexual Orientation: Y N P
Dexa Scan: Y N P

Use of hormones: Y N P
Type of hormones used: _____
Last Pap Smear: Y N P
Diagnosis: _____
Healthy libido: Y N P
Vaginitis: Y N P
Mammography: Y N P

If yes, what were the results: _____
Please list any birth control used and ages used: _____

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

Have you had any jobs where you were exposed to solvent, heavy metals, fumes or other toxic materials?

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing?

Are you particularly sensitive to perfumes, gasoline or other vapors?

Do you particularly use pesticides, herbicides or other chemicals around your home? If so, please list.

Anything else I should know?

_____

_____

_____

_____