Roots Medical
Getting to the Root of your healthcare concerns

3525 S Tamarac Dr. #170
Denver, CO 80237
P: (720) 390-5148
F: (720) 729-0108
info@rootsmedical.net
www.rootsmedical.net

Patient Intake Questionnaire

All questions contained in the questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):		Today's Date:	

Surgeries (what & when)	Hospitalizations (what & when)

Women Only

Past symptoms of PMS:				Current symptoms of PMS:				
Pregnancies #:		Births #:		Miscarriages #:		Abortions #:		☐ Preclampsia ☐ Gestational Diabetes
How did you feel during pregnancy?				How did you feel on birth control?				
Age of Menopause:		Have you had a partial/total hysterectomy (please circle if yes):						☐ yes ☐ no
Do you have any family history of breast cancer on your mother's side, children or sisters?								☐ yes ☐ no

Family History

Relative:	Diseases (with age of onset):	If deceased (list age & cause):
Mother:		
Father:		
Siblings:		
Children:		

Screening

Last Colonoscopy (and results):		Please list any history of STDs:			History of abnormal PAP smears:		
Last Transvaginal U/S (and results):		Last DEXA bone scan (and results):		Last thyroid Ultrasound (and results):		Endoscopy (and results):	
Other tests:							

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Medications & Supplements

Name	Dosage	How Often	For what Condition	Prescriber

Allergies
(include medications, supplements, food and substances)

Allergen	Reaction

Past Medical Diagnosis

Condition	Year Diagnosed	Treatment	Practitioner

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List Current Doctors or Health Care Providers	

Current Health Complaints	
#1	
#2	
#3	

Current Symptoms (please check yes or no)

Cold Intolerance: yes ☐ no ☐
Constipation: yes ☐ no ☐
Brittle Hair/Nails: yes ☐ no ☐
Fatigue: yes ☐ no ☐
Hair Loss: yes ☐ no ☐
Heat Intolerance: yes ☐ no ☐
Irritability: yes ☐ no ☐
Mental Fogginess: yes ☐ no ☐
Weight Gain/Loss: yes ☐ no ☐

PMS Symptoms: yes ☐ no ☐
Menopause Sym.: yes ☐ no ☐
Tired After Meals: yes ☐ no ☐
Sweet Cravings: yes ☐ no ☐
Hypoglycemic: yes ☐ no ☐
Erectile Dysfunc.: yes ☐ no ☐
Low Sex Drive: yes ☐ no ☐
Muscle Loss: yes ☐ no ☐

How did you hear about Roots Medical?_____

I testify that the information above is the truth to the best of my knowledge.

Patient's Signature:_____Date:_____

Patient's Guardians Signature:_____Date:_____