



3525 S Tamarac Dr. #170
 Denver, CO 80237
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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 #:	
						<input type="checkbox"/> Preclampsia <input type="checkbox"/> 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):				<input type="checkbox"/> yes <input type="checkbox"/> no	
Do you have any family history of breast cancer on your mother's side, children or sisters?						<input type="checkbox"/> yes <input type="checkbox"/> 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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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: _____