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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 #:		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:							

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: _____