Medical Intake Form Preface

Greetings,

Thank you for taking the time to visit my practice website, office space, and your interest in being cared for by Sunrise Family Medicine PLLC. I am honored that you have considered participating in my integrative care model that incorporates multiple facets of medicine to care for the whole person. Whether you are seeking Direct Primary Care, Osteopathic Manual Medicine, Traditional Chinese Acupuncture or a combination of these, rest assured you will get the benefit of all these practices indirectly as the disciplines work together in theory and philosophy to take care of the mind, body, and spirit. With that in mind, I am grateful for your kindness, patience, and mindfulness as you complete your medical intake forms as they have been formulated thoughtfully to give me the best idea about your concerns and struggles. Sharing your story helps me understand better who you are, where you have been, and where you are going, and want to go medically, physically, mentally. I understand there are a lot of questions. They help paint a picture of your journey. If something does not apply to you or there is no history to give on a particular item, mark none or not applicable.

The bigger picture matters. Your story matters.

Thank you for trusting the process.

Sincerely,

Dr. Tuan M Vo DO

Osteopathic Traditional Medical Intake Form

Legal Name: _____

Nick name or preferred name: _____

Date of Birth: _____

Birthplace/nationality: _____

Sex at birth/Gender/Pronouns: _____

Home Address: _____

_____

Telephone # (Home: H; Cell: C): _____

Email: _____

Preferred contact method/ Best time of day: _____

Emergency contact(relationship)/Phone: _____

Preferred hospital: _____

Pharmacy (Cross streets) #1/#2:_____

How did you hear about us: _____

Services you seek: DPC-Family Medicine _____ OMT/OMM _____ TCM-Acupuncture _____

Main issue(s) you are seeking guidance on (list in order of importance): _____

_____

_____

How do you consider your health status including physical, mental, emotional, functional?

_____

_____

Medication Allergies: Please list the medicine, side effect(s), severity, date it first occurred, how it was/is treated. Write NONE if no allergies. (If you do not have enough room, please attach a separate sheet.)

_____
_____

_____

_____

_____

Medications: Please list your prescribed/over the counter medications then supplements separately. Please include the dosage, how often you take it, and why you take that medication or supplement, and for how long you have been taking them if possible. (If you do not have enough room, please attach another sheet, or fill in sheet at the end.) Write NONE if no meds.

_____
_____
_____

_____

_____

_____

_____

_____

_____

Past Medical history: Please list medical condition(s), year diagnosed, past-current, treatment.

_____
_____
_____

_____

_____

_____

_____

_____

Please Mark the symptoms you are experiencing and may want to discuss.

General	**Joint/Musculoskeletal**	**Skin**
☐ Fatigue	☐ Joint Pain/Stiffness	☐ Easy Bruising
☐ Fever	☐ Joint Inflammation	☐ Rash
☐ Weight loss/gain >10lbs	☐ Joint Redness	☐ Skin lesions
Psychiatric	☐ Muscle Weakness	☐ Itching, dryness
☐ Depression/anxiety	☐ Muscle pain/aches	**Breast**
☐ Suicidal thoughts	☐ Decreased/increased motion	☐ Breast pain/discharge /bleeding
☐ Changes in sleep	**Neck**	☐ Breast lump, dimpling
☐ Hallucinations	☐ Masses	☐ Skin changes
☐ Anger/Mood swings	☐ Neck pain	
☐ Memory issue	☐ Swollen Glands	

Eye/Ear/Nose/Throat	**Pulmonary**	**Cardiovascular**
☐ Ear pain	☐ Chronic cough	☐ High/low blood pressure
☐ Hearing loss	☐ Trouble breathing	☐ Palpitations
☐ Hoarseness	☐ Shortness of breath	☐ Chest pain
☐ Nose bleeds	☐ Excess phlegm	☐ Swelling of the arms/legs
☐ Ringing in the ears	☐ Wheezing	☐ Rapid/slow heartbeat
☐ Throat pain, irritation	☐ Coughing up blood	☐ Leg pain with walking
☐ Vision changes	**Hematologic**	☐ Varicose veins
☐ Allergies/Nasal Drip	☐ Easy, long bleeding	
	☐ Enlarged nodes	

Gastrointestinal	**Genitourinary**	**Endocrine**
☐ Abdominal pain	☐ Blood in urine	☐ Cold/hot intolerance
☐ Bloody or dark stools	☐ Trouble urinating	☐ Weight changes
Rectal bleeding	☐ Urinary Incontinence	☐ Appetite change
☐ Constipation, Gas	☐ Kidney stones	☐ Increased thirst
☐ Diarrhea	☐ Urgency, frequency	☐ Increased urination
☐ Nausea	☐ Painful urination	☐ Hair changes
☐ Vomiting	☐ Sexual dysfunction	☐ Skin discoloration
☐ Vomiting blood	☐ Menopausal symptoms	☐ Sweating
☐ Trouble swallowing	☐ Vaginal discharge	

Neurological

- ☐ Loss of bowel control/ Loss of bladder control
- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness/tingling
- ☐ Passing out, Loss of consciousness

Individuals with menstrual cycles

Name of OBGYN/Women's Health Provider:_____

Menstrual flow:

Length of cycle/pattern (days): _____

Heavy/Med/Light (#/type pads): _____

First day of last period (date): _____

Past Pregnancies (include live births, miscarriages, abortions): _____

_____

Difficulties with labor/deliveries: _____

Current Birth control: _____

Past Birth control: _____

Any Hormone Replacement Therapy: _____

Date last pap smear/history of abnormal pap: _____

Date last mammogram/history of abnormal results: _____

Date last DEXA scan: _____

Check any conditions you have or have had that may not have been mentioned above:

- ☐ Alcoholism
- ☐ Addiction, illicit substances, prescription meds, other
- ☐ Anemia
- ☐ Appendicitis
- ☐ Atherosclerosis, Clogged arteries in the heart
- ☐ Asthma
- ☐ Bronchitis
- ☐ Blood Clots
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Colitis/Crohn's
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Dementia
- ☐ Eczema
- ☐ Edema
- ☐ Ehlers Danlos Syndrome
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gall Bladder Disease
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ GI Bleeding
- ☐ Goiter
- ☐ Gout
- ☐ Guillan Barre
- ☐ Heart Attack
- ☐ Heart Burn
- ☐ Heart Murmur/Valve Issues
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ IBS-C/D
- ☐ Influenza
- ☐ Long Covid Syndrome
- ☐ Malaria
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker/Defibrillator
- ☐ Parkinson's
- ☐ Parasitic Infection
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Spinal Stenosis
- ☐ SLE/Lupus
- ☐ Stroke/TIA
- ☐ Temporal Arteritis
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vertigo
- ☐ Other Sexual Infections

Have you had trauma, social injustice, insecurity, discrimination? When/Treatment?

_____

_____

_____

_____

Past Surgical history: Please list all surgeries, month, and year completed, elective/emergency?

_____

_____

_____

_____

_____

_____

_____

Past hospitalizations: Please list all hospitalizations, which hospital, and dates they occurred.

_____

_____

_____

Family History: List Member, Disease, Treatment, if they are living or deceased. If they are deceased, list the cause of death, and age when they passed away.

Immediate Family: _____

_____

_____

_____

Extended Family: _____

_____

_____

_____

_____

Social History:

Occupation: _____

How long have you had this job: _____

How many hours do you work a day/week: _____

Do you take work home/work weekends: _____

What repetitive movements do you do and for how long: _____

_____

How many hours do you sit/stand a day: _____

How many hours do you look at a screen: _____

Do you take breaks at work? (How long/often?) _____

Do you enjoy work: _____

Is this your ideal job/if not what is: _____

Relationship (Single/Married/Divorced/ partnered, open, poly, other):

_____

Children:_____

Education/vocational training: _____

_____

Living situation (home, apt, etc, house mates?): _____

Pets: _____

Religion/Spirituality: _____

List your daily activities/time spent: _____

_____

List hobbies/ time spent: _____

_____

How do you relax/enjoy yourself/time spent? _____

_____

Past Travel (US/International): _____

Travel past 12 months: _____

Answer the following using: Y/N

Over 2 weeks to 2 months have you felt:

Less interest or pleasure in doing things? _____

Down, depressed, or hopeless? _____

Trouble falling, staying asleep, sleeping too much? _____

Feeling tired, having little energy?_____

Poor appetite, or overeating, stress eating? _____

Trouble concentrating on simple things like reading, looking at the phone? _____

Over last 2 weeks to 2 months have you felt:

Feelings nervous, anxious, or on edge? _____

Not being able to stop or control worrying? _____

Being easily annoyed or irritable? _____

The following questions are to grade how sleepy you get with normal activity. Please answer using the following scale:

No chance of dozing = 0; Slight chance =1, Moderate chance =2, High chance = 3

Watching TV: _____

Sitting inactive in a public place: _____

As a passenger in a care for an hour without a break: _____

Lying Down to rest in the afternoon when circumstances permit: _____

Sitting and talking to someone: _____

Sitting quietly after a lunch without alcohol: _____

In a car, while stopped for a few minutes in traffic: _____

Habits:

Tobacco use:

- Have you ever smoked? If so for how long/how many packs per day?
  _____
- When did you quit smoking if you have done so? _____
- If you are not a smoker, have you had second or third hand smoke exposure? Have you experienced any chronic cough or recurrent respiratory symptoms?
  _____
  _____

Vape use:

- Do you vape or inhale any combustible products? How often/how much?
  _____

Alcohol use (# per day/wk/mo): _____

Illicit Substance use(# per day/wk/mo):

_____

Sleep:

- How many hours do you sleep a night? Wake up rested?_____
- What time do you go to bed? Get up? _____
- How many times do you wake up at night? Why? Can you get back to sleep easily?

  _____
- Do you need a sleep aide? What and how do you take it? _____
  _____
- What is your routine and activity before bedtime? _____
  _____

Exercise: min/day/wk/kind of activity: _____

_____

Electronic/Social Media Use:

- How many hours a day do you use electronics?_____
- How many times a day do you engage on social media? _____
- Do you use electronics in the evening and before bedtime? _____

Diet/Food: give examples of the meals you have

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Soft drinks (cans/day): _____

Caffeine (cup/day): _____

Sugar: _____

Water (Glass/day): _____

Salty food: _____

Do you like cold or hot drinks more? _____

How is your appetite? Poor/Excessive? _____

What foods and flavors do you crave most? _____

Dental health:

- How is your dental health? Good, Fair, Poor? _____
- When was your last Dental cleaning/visit? _____
- How often do you brush and floss your teeth? _____
- Do you have problems with bad breath?_____

Please check which vaccinations you have received, attached your record if you have it.

☐ Hepatitis A ☐ Hepatitis B ☐ Tetanus/Tdap/Td

☐ Influenza Vaccine ☐ COVID-19 ☐ Pneumococcal

☐ RSV ☐ Meningococcal A ☐ Meningococcal B

☐ Measles, Mumps & Rubella Vaccine ☐ Varicella/Zoster-Shingles Vaccine

☐ Human Papilloma Virus ☐ Monkeypox

Last doctor visit (date/reason): _____

Current Primary Care Doctor: _____

Name and expertise of Specialists /Therapists : _____

_____

_____

_____

_____

_____

What would you like to change or improve with your health over time?

- 1 month: _____
- 3 months: _____
- 6 months:_____

What are the top 3 priorities in your life? _____

1._____

2._____

3._____

You agree that you have answered the above to the best of your knowledge.

Name/Initials: _____

Date: _____

Thank you for completing this form.

SUNRISE FAMILY MEDICINE, PLLC
DR. TUAN M. VO, DO, MPH