**Willowbrook Health Center**
**4 Willowbrook Rd**
**Cromwell, Connecticut, US - 06416**

# Dr. Sara's Male Intake Form_2022

## General Information

Which pronouns do prefer? ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their

Best phone number to reach you at: *

Preferred method of contact : * ☐ Phone Call ☐ Text Message ☐ Email

Mailing address (street with number, town, zip code) *

How were you referred to Dr. Sara? * ☐ Patient Referral ☐ Yelp/Google ☐ Facebook/Website ☐ Insurance ☐ Friend or Family Member

If you were referred by a current patient of Dr. Sara's please let us know by who so we can contact them to say thanks

Health Insurance Provider *

Insurance Group Number: *

Insurance policy number: *

Do you have a copay or a deductible? What is it?

Credit Card Number (only charged for drop ship supplements orders and/or late appointment cancellations or no shows) *

Credit Card Expiration Date (mm/yy) *

Credit Card CVV Code *

Billing Zip Code *

Marital status * ☐ Single ☐ Married ☐ In a relationship

Height : *

Weight : *

Occupation : *

Emergency Contact Name : *

Phone : *

Relationship : *

## Medical History

Primary health care provider : *

Other healthcare providers: *

List your chief health concerns in the order of importance to you. Also include when they started. *

List any medical diagnosis you have received (i.e. diabetes, heart disease, depression, etc.) *

List any prescription medications you take including dosages and reason for taking them *

List any over counter medications or supplements you take and the reason for taking them *

Any known allergies to medications? * ☐ Yes ☐ No

If yes, specify them

Any known food or environmental allergies? * ☐ Yes ☐ No

If yes, specify them

Are any of your allergies life threatening? * ☐ Yes ☐ No

If yes, specify them

Have you taken any antibiotics in the last year * ☐ Yes ☐ No

If yes, how many times? _____

## Family History (esp heart disease, cancer, anxiety/depression):

Ages & Chronic Diseases of:

Mother:

Father:

Sibling(s):

Grandparents:

Aunts/Uncles:

## Symptoms

**General :**

Sleep disturbance * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Fatigue * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Exposure to toxic chemicals * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Iron deficiency anemia * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

**Head**

Headaches or migraines * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Difficulty concentrating * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Memory problems * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

History of Head injury * ☐ Yes ☐ No

**Ears, Eyes, Nose, Throat**

| | | | |
|---|---|---|---|
| Frequent colds * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Sinus congestion or infections * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Mouth sores * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Dental/gum infections * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Dry eyes * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |

**Skin**

| | | | |
|---|---|---|---|
| Acne * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Dry skin * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Easy bruising/bleeding * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Skin rashes * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |

**Digestion**

| | | | |
|---|---|---|---|
| Stomach pain and or/ cramps * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Acid reflux / heartburn * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Abdominal bloating or gas * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Nausea or vomiting * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |

**Mental / Emotional**

| | | | |
|---|---|---|---|
| Mood swings or mood disorders * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Irritability * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |

| | | | |
|---|---|---|---|
| Depression * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Anxiety/nervousness * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |

**Cardiovascular**

| | | | |
|---|---|---|---|
| Heart disease * | ☐ Yes | ☐ No | ☐ In the past |
| High blood pressure * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Heart palpitations * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Cold hands and feet * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Varicose veins * | ☐ Yes | ☐ No | ☐ In the past |
| Swelling of hands and feet * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |

**Respiratory**

| | | | |
|---|---|---|---|
| Chronic Cough * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Asthma * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Shortness of breath * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Sleep apnea * | ☐ No ☐ In the past | ☐ Mild | ☐ Severe |

**Neurological**

| | | | |
|---|---|---|---|
| Seizures * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Numbness and tingling * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |
| Loss of balance * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |

**Musculoskeletal**

| | | | |
|---|---|---|---|
| Joint pain or stiffness * | ☐ Often ☐ In the past | ☐ Sometimes | ☐ Never |

| | | | |
|---|---|---|---|
| Neck/back pain * | ☐ Often | ☐ Sometimes | ☐ Never |
| | ☐ In the past | | |
| Muscle weakness * | ☐ Often | ☐ Sometimes | ☐ Never |
| | ☐ In the past | | |
| Muscle spasms or cramps * | ☐ Often | ☐ Sometimes | ☐ Never |
| | ☐ In the past | | |
| Osteopenia/osteoporosis * | ☐ Yes | ☐ No | ☐ In the past |

**Urinary**

| | | | |
|---|---|---|---|
| Burning or pain during urination * | ☐ Often | ☐ Sometimes | ☐ Never |
| | ☐ In the past | | |
| Frequent urination at night * | ☐ Often | ☐ Sometimes | ☐ Never |
| | ☐ In the past | | |
| Inability to hold urine * | ☐ Often | ☐ Sometimes | ☐ Never |
| | ☐ In the past | | |
| Bladder infections * | ☐ Often | ☐ Sometimes | ☐ Never |
| | ☐ In the past | | |

**Endocrine**

| | | | |
|---|---|---|---|
| Low libido * | ☐ No | ☐ Mild | ☐ Moderate |
| | ☐ Severe | ☐ In the past | |
| Easy weight gain * | ☐ Often | ☐ Sometimes | ☐ Never |
| | ☐ In the past | | |
| Hair loss * | ☐ No | ☐ Some | ☐ Yes |
| | ☐ In the past | | |
| Heat or cold intolerance * | ☐ Often | ☐ Sometimes | ☐ Never |
| | ☐ In the past | | |
| Thyroid problems * | ☐ No | ☐ Mild | ☐ Severe |
| | ☐ In the past | | |
| Blood sugar problems * | ☐ Often | ☐ Sometimes | ☐ Never |
| | ☐ In the past | | |

**For Men :**

| | | | |
|---|---|---|---|
| Prostate problems * | ☐ Yes | ☐ No | ☐ In the past |
| Erectile dysfunction * | ☐ Often | ☐ Sometimes | ☐ Never |
| | ☐ In the past | | |
| Use of Viagra * | ☐ No | ☐ Sometimes | ☐ Yes |
| | ☐ In the past | | |

Difficult urination * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

## Lifestyle

How many alcoholic drinks per week? * ☐ None ☐ 0-2 ☐ 2-4 ☐ 4+

Do you smoke? * ☐ Yes ☐ No ☐ In the past

Rate your current stress level(10 being the highest) * ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What are the primary sources of your stress? *

Do you have any dietary restrictions (religious, vegetarian, vegan, etc.)? *

## Health Goals

What are your main health goals? *

How willing are you to change your eating habits to reach your goal? * ☐ Strongly willing ☐ Moderately willing ☐ Not willing ☐ Cannot say

What is your timeframe for reaching your goal? *