New Patient Form

Name:

Mailing Address:

Email Address:

Preferred Communication: phone email mail
Primary phone number:
Home Phone:
Cell Phone:
Work Phone:
Is it ok to leave messages on the above phone number regarding specific information to your health: YES NO

Allergies to Medications:

How did you hear about IHC:

Primary Care Provider (IHC is not a primary care provider, patient must continue to see current PCP
Name:
Number:
Address

If under 18 years of age: Primary Care Giver:
Name:
Number:
Relationship:

Food Allergies:

Food	Reaction	Severity

Food Intolerances:

Food	Reaction	Severity

Environmental Allergies:

Allergen	Reaction	Severity

Diagnosis:

Diagnosis	Doctor Name & Specialty	Date

List of your current medical providers & specialty:

Provider & Specialty	Address	Phone

List of your current supplements:

Drug	Dose	Start Date

Are you up-to-date on vaccinations? YES NO

List any Hospitalizations/Surgeries (place, reasons & dates)

Name and Location	Reason	Date

Patient's Brothers/Sisters and their Children

List your brothers/sisters.

Please include stillbirths(sb), miscarriages(m) and those deceased(d).

Name of Sibling	Date of Birth	Sex	Present Health	Sibling's Children

Are any of the above half-brothers/sisters and/or step-brothers/sisters?_____
_____

Are any of the above adopted or foster children?_____
_____

Biological Mother

Date and place of birth_____
Ethnic origin_____
Present Health_____
_____
_____

Maternal Grandfather

Ethnic origin_____

Date & Place of Birth_____

How many brothers? _____

How many sisters? _____

Present Health (if deceased, date and cause of death)_____
_____

Maternal Grandmother

Ethnic origin_____

Date & Place of Birth_____

How many brothers? _____

How many sisters? _____

Present Health (if deceased, date and cause of death)_____
_____

Is there anyone else on the maternal side of the family that has any birth defects, mental retardation, or any other health concerns not yet mentioned? List each person affected and identify the problems.

_____
_____
_____ Biological

Biological Father

Date and place of birth_____

Ethnic origin_____

Present Health_____
_____
_____

Paternal Grandfather

Ethnic origin_____

Date & Place of Birth_____

How many brothers? _____

How many sisters? _____

Present Health (if deceased, date and cause of death)_____
_____

Paternal Grandmother

Ethnic origin_____

Date & Place of Birth_____

How many brothers? _____

How many sisters? _____

Present Health (if deceased, date and cause of death)_____
_____

Is there anyone else on the paternal side of the family that has any birth defects, mental retardation, or any other health concerns not yet mentioned? List each person affected and identify the problems.

_____
_____
_____

Patient's Children

List your children

Please include stillbirths(sb), miscarriages(m) and those deceased(d).

Name of Child	Date of Birth	Sex	Present Health	Grand Children
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Dental Health

Do you visit the dentist every 6 months? YES NO

When was the last time you went to the dentist?

Do you have any cavities? YES NO

If yes, how many?

What color are the fillings?

When did you get the fillings (year and age):

Have you ever had any fiillings removed?

Have you ever had a root canal?

If yes, how many? (Year, Age):

Travel

Have you lived or traveled outside the USA? YES NO

Where and when?

Did you fall ill during or after a trip?

Have you ever traveled or lived on the East Coast?

Minnesota?

Wisconsin?

Have you ever been bit by a tick?

Have you ever had a bullseye rash?

Have you ever lived or worked in a building with a known mold problem?

Environmental Exposure

Have you ever been exposed to known heavy metals at work or home?

Have you ever lived in a home with well water?

Have you been exposed to broken florescent light bulbs?

Have you been exposed to broken mercury thermometers?

Have you been exposed to a dental office besides normal checkups?

List all your past and present occupations

_____
_____
_____

Other Exposures

_____
_____
_____