3205 East Washington Avenue Madison, WI 53704 608.222.2700 www.familynaturalmedicine.com info@familynaturalmedicine.com

PATIENT'S PERSONAL INFORMATION

Patient's Name				Sex:	M☐	F☐
	Last	First	Middle			
Date of Birth		Marital Status:	Single☐	Married☐	Divorced☐	Others☐
Occupation						
Address		City		State		Zip
E-mail						
Phone Number:	Home		Work		Cell	
Referred by						
Employer Information						
Employer						
Address		City		State		Zip
☐Full Time	☐Part Time	☐Retired	☐Disabled	☐Unemployed		
Emergency Contact						
Name		Relationship		Phone #		
Address		City		State		Zip
If someone other than the patient is responsible for payment please complete below.						
Insured's Name		Sex:	M☐	F☐	Date of Birth	
Relationship to Patient	☐Spouse	☐Child	Other (Specify)			
Address		City		State		Zip

Can we send you the following information electronically?		email address	
•Information about your herbs and supplements?	Yes ☐	No☐	
•Newsletter from The Siloam Center for Traditional and Integrative Medicine LLC?		Yes ☐	No ☐
•Information about a potential treatment options or alternatives?		Yes ☐	No ☐
• Appointment reminders?	Yes ☐	No ☐	

Family History: Does your mother, father, grandparents, brothers, sisters, aunts, uncles, or children have any of the following? If yes, who? If family history is unknown, please check unknown.

☐ Unknown/Adopted

Yes ☐	No ☐	**Allergy**. If yes, who?	
Yes ☐	No ☐	**Bleeding Disorder**. If yes, who?	
Yes ☐	No ☐	**Cancer**. If yes, who?	
Yes ☐	No ☐	**Depression**. If yes, who?	
Yes ☐	No ☐	**High Blood Sugar (Diabetes)**. If yes, who?	
Yes ☐	No ☐	**High Blood Pressure**. If yes, who?	
Yes ☐	No ☐	**Heart Problems**. If yes, who?	
Yes ☐	No ☐	**Lung Problems (Asthma)**. If yes, who?	

Social History:

Substance Abuse:					
Cigarette Smoking?	Yes ☐	No ☐	Packs per day		How long?

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Past Smoking?	Yes ☐	No ☐	What year did you quit?		
Smoke Exposure?	Yes ☐	No ☐			
Do you drink alcohol?	Yes ☐	No ☐	How many alcoholic drinks per week?		
Any drug use?	Yes ☐	No ☐	What type of drug?		
Living Situation:					
Are there pets in the home?	Yes ☐	No ☐	If yes, what type of pet?		
Exercise/Diet:					
Exercise?	Yes ☐	No ☐	If yes,	x/week	Type
Diet?	☐ Regular	☐ Diabetic	☐ Low Fat	☐ Low Salt	☐ Other
Hobbies?					

Review of Systems: Please check the "Yes" or "No" box to indicate if you have any of the following symptoms. For any "Yes" response, please check the "Current" box if this symptom relates to the reason for your visit today.

	Yes	No	Current		Yes	No	Current
General				**Breast**			
Chills	☐	☐	☐	Breast pain	☐	☐	☐
Fever	☐	☐	☐	Breast lump	☐	☐	☐
Fatigue	☐	☐	☐	Nipple discharge	☐	☐	☐
Night Sweating	☐	☐	☐	**Gastronintestinal**			
Weight gain/loss	☐	☐	☐	Difficulty in swallowing	☐	☐	☐
Daytime sleepiness	☐	☐	☐	Heartburn	☐	☐	☐
Sleeping difficulties	☐	☐	☐	Nausea	☐	☐	☐
Allergy				Abdominal pain	☐	☐	☐
Environmental Allergy	☐	☐	☐	Stomach pain	☐	☐	☐
Sneezing	☐	☐	☐	Constipation	☐	☐	☐
Dermatology (Skin)				Diarrhea	☐	☐	☐
Rash	☐	☐	☐	Black, tarry stool	☐	☐	☐
Itching	☐	☐	☐	**Female Genitourinary**			
Hives	☐	☐	☐	Blood in urine	☐	☐	☐
Changes in Moles	☐	☐	☐	Urination difficulty	☐	☐	☐
Scalp problems	☐	☐	☐	**Neurological**			
Hair changes	☐	☐	☐	Dizziness	☐	☐	☐
Bruising	☐	☐	☐	Faintness	☐	☐	☐
Yellowing of skin	☐	☐	☐	Headache	☐	☐	☐
New lesions	☐	☐	☐	Memory problems	☐	☐	☐
Eyes				Seizures	☐	☐	☐
Eye pain/pressure	☐	☐	☐	Tremors	☐	☐	☐
Visual disturbances	☐	☐	☐	Weakness of limbs	☐	☐	☐
	Yes	No	Current		Yes	No	Current
ENT				**Psychiatric**			

Ear ache	☐	☐	☐		Anxiety	☐	☐	☐
Ring in ears	☐	☐	☐		Mood swing	☐	☐	☐
Dizziness	☐	☐	☐		Depression	☐	☐	☐
Decreased hearing	☐	☐	☐		Change in sleep pattern	☐	☐	☐
Nasal congestion	☐	☐	☐		**Endocrine**			
Nose bleeding	☐	☐	☐		Appetite change	☐	☐	☐
Snoring	☐	☐	☐		Excessive thirst	☐	☐	☐
Throat clearing	☐	☐	☐		Hot flashes	☐	☐	☐
Sore Throat	☐	☐	☐		**Hematology**			
Throat hoarseness	☐	☐	☐		Anemia	☐	☐	☐
Respiratory					Blood clots in legs/lungs	☐	☐	☐
Cough	☐	☐	☐		Easy bruising	☐	☐	☐
Wheezing	☐	☐	☐		Bleeding problem	☐	☐	☐
Shortness of breath	☐	☐	☐					
Coughing up blood	☐	☐	☐					
Sputum production	☐	☐	☐					