UNM CENTER for LIFE
Preventive & Integrative Medicine Specialty Clinic

Please tell us about yourself

Thank you for choosing the Center for Life (CFL) a preventive and integrative medicine specialty clinic. We're committed to providing you healthcare that is unique to your mind, body and spiritual needs. In order to provide you comprehensive integrative care, we ask that you take a few extra moments to give us as much information as possible.

Name: _____ Date of Birth: _____ ▫ Male ▫ Female
Address: _____ City: _____ State: _____ Zip: _____
Phone: 1st Choice _____ 2nd Choice _____

Your experience at the Center for Life is important to us. New healthcare regulations require that:

- We collect patient satisfaction data. If the company who performs these surveys contacts you, would you prefer they contact you via email or telephone? ▫ Email ▫ Telephone
- We have a patient portal where you can access portions of your healthcare record. We will need your email address in order to give you access to the patient portal.
- Email Address: _____
- Would you like to receive information on upcoming CFL events & classes at this email? ▫ Yes ▫ No

Why are you here today?

_____
_____
_____
How long have you had this problem? _____
Do you have other problems you want to talk about? _____

What medical problems do you have?

What medical problems do you have? _____
_____
_____

Have you had any operations? ▫ Yes ▫ No
What & When: _____
_____
Have you had a recent injury? ▫ Yes ▫ No
What & When: _____

Where do you get your medicines?

Name of Drug Store: _____
Address or near what main cross streets?
_____
City: _____ State: _____ Zip: _____
Phone: _____
Do you have medicine bottles with you?
▫ Yes ▫ No

Do you have any allergies to medicine, food, or the environment?

Allergen	Reaction
_____	_____
_____	_____
_____	_____

What medicines (prescription & over-the-counter) do you take?

Medicine:	How Much:	Company:	How Often:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take vitamins, supplements, or herbs?

Product	How Much?	How Often?
_____	_____	_____
_____	_____	_____
_____	_____	_____

What problems have you had in the past 6 months?

General
- ☐ Weight loss/gain
- ☐ Fever
- ☐ Low energy

Eyes
- ☐ Pain
- ☐ Discharge (oozing)
- ☐ Light hurts your eyes
- ☐ Blurred vision

Ears, Nose, Throat
- ☐ Sore or dry throat
- ☐ Hoarseness
- ☐ Ear ringing
- ☐ Nose bleeds
- ☐ Snoring

Lungs
- ☐ Wheezing
- ☐ Cough
- ☐ Hard to breath
- ☐ Coughing up blood

Heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Fainting
- ☐ Rapid heartbeat
- ☐ Feet swelling

Stomach
- ☐ Pain
- ☐ Nausea/vomiting
- ☐ Watery stool
- ☐ Can't pass stool
- ☐ Unusual color stool
- ☐ Strong smelling stool
- ☐ Change in appetite

Urine/Kidney
- ☐ Problems urinating
- ☐ Pain when urinating
- ☐ Blood in urine (pee)
- ☐ Urine (pee) smells bad
- ☐ Urgent need to pee
- ☐ Impotency/prostate

Brain/Nerves
- ☐ Headache
- ☐ Confusion
- ☐ Numbness
- ☐ Slurred speech
- ☐ Seizure
- ☐ Difficulty concentrating

Hormones
- ☐ Sweating a lot
- ☐ Thirsty all the time
- ☐ Feeling hot all the time
- ☐ Feeling cold

Muscle/Bones
- ☐ Joint swelling
- ☐ Joint redness
- ☐ Joint pain
- ☐ Problems

Blood/Glands
- ☐ Bleed easily
- ☐ Bruise easily
- ☐ Blood clots
- ☐ Swollen glands

Skin/Breast
- ☐ Rash
- ☐ Lumps/bumps
- ☐ Itching
- ☐ Sores
- ☐ Infections
- ☐ Liquid coming out

Mental Health
- ☐ Anxiety or nerves
- ☐ Depressed (feel sad all the time)
- ☐ Too much stress
- ☐ Panic attacks

Female System
- ☐ Heavy bleeding with period
- ☐ Painful periods
- ☐ Discharge from vagina
- ☐ Pain with sex
- ☐ Other _____

Female History (For Women Only)
Are you or could you be pregnant? ☐ Yes ☐ No
Are you or your partner using birth control? ☐ Yes ☐ No
Date your last period started? _____
How long was last period? _____
Age of first period? _____
How many times have you been pregnant? _____
Number of babies born alive? _____
Number of living children? _____
Have you taken hormone pills? ☐ Yes ☐ No
Have you taken birth control pills? ☐ Yes ☐ No
Are you planning on having children? ☐ Yes ☐ No
Have you ever had a breast biopsy? ☐ Yes ☐ No

Male and Female Preventive Screening
Have you had these preventive tests?
Colonoscopy: ☐ Yes _____ (Year) ☐ No
Cholesterol test: ☐ Yes _____ (Year) ☐ No
Flu shot: ☐ Yes _____ (Year) ☐ No
Prostate screening: ☐ Yes _____ (Year) ☐ No
Mammogram: ☐ Yes _____ (Year) ☐ No
PAP smear: ☐ Yes _____ (Year) ☐ No

Your Family's Health Problems
Has anyone in your family had problems with?

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Lungs
- ☐ Gallbladder or liver
- ☐ Thyroid
- ☐ Stroke
- ☐ Bleeding
- ☐ Muscle or bone
- ☐ Diabetes
- ☐ Hart
- ☐ Stomach/intestines/colon
- ☐ Pancreas
- ☐ Kidney or urine
- ☐ Seizures
- ☐ Blood clots

Your Social History
Do you smoke cigarettes?
☐ No ☐ Yes _____ packs/day
How many years? ___
Do you drink alcohol?
☐ No ☐ Yes _____ glasses or beers per day/week
Do you use drugs not given to you by a doctor?
☐ No ☐ Yes What kinds? _____