Schneck Integrative Medicine
Dr. Steve Windley / Sherry Arbuckle FNP-C

- **Please arrive at least 20 minutes before your appointment for check-in.** While we will do our best to accommodate you, arriving late may require us to reschedule your appointment.
- **If you need to reschedule, kindly provide at least one business days' notice.**
- **Remember to bring your insurance cards and a photo ID.**
- **Please complete the new patient paperwork before your visit.** If you are unable to complete it in advance, please arrive 40 minutes early to allow enough time.
- **If you have lab results, you may send them to us prior to your appointment.** You can fax them to the provider at (812) 523-5869 or submit them through the Schneck Medical Center patient portal. If you need assistance with the portal please call our office (812)523-5865 and a member of our team would be happy to assist you.
- **Additionally, please create a list of goals for your visit, as the provider will discuss these with you at the beginning of your appointment.**

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209 S. WALNUT ST. SEYMOUR INDIANA

MALE Personal History Form

Your appointment:

Name: _____ Date of Birth_____

PRIMARY CARE DOCTOR: _____ (DR WINDLEY IS NOT A PRIMARY CARE DOCTOR)

Major Symptoms

What brings you in today (major complaint)? _____
How frequent and severe are your symptoms? _____
How long have you had these symptoms? _____
What makes your symptoms worse? _____
What makes your symptoms better? _____
How do your symptoms interfere with your daily life, family life and career?

_____
_____
_____

Please list treatments you have received so far.

What test, medicines and consultations have been done so far?

_____
_____
_____

Have any of these treatments helped?

_____
_____

Were there any complications with any previous treatments?

_____
_____

List all known allergies to food, medications, and environment:

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Medications/Supplements

Please list all prescriptions, over the counter medications, and supplements you currently take.

Medication/Supplement	Dose/Strength	How often you take it

Over the last 2 weeks, how often have you been bothered by the following problems?

Please place a number next to the question.

Not at all - 0

Several days- 1

More than half the days- 2

Nearly every day - 3

1. Little interest or pleasure in doing things
2. Feeling down, depressed or hopeless
3. Feeling nervous, anxious, or on edge
4. Not being able to stop or control worrying
5. Worrying too much about different things
6. Trouble relaxing
7. Being so restless that it's hard to sit still
8. Becoming easily annoyed or irritable
9. Feeling afraid as if something awful might happen

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Social History

Who lives at home bedsides you?_____

Are they healthy? _____

Marital status:_____ Number of children_____

Do you use any tobacco products? ☐ Cigarettes ☐ Chewing Tobacco ☐ Vaping ☐ None

If yes, how many years? _____

Are you exposed to second hand smoke often? ☐ Yes ☐ No

Alcohol use ☐ Yes ☐ No How many drinks per week _____

Physical, mental or Sexual abuse ☐ Yes, Which one _____ ☐ No

Previous Medical History - Please check any conditions that apply to you.

☐ Hypothyroidism ☐ Chronic Fatigue ☐ Fibromyalgia ☐ Hypoglycemia

☐ Irritable bowel syndrome

☐ High cholesterol ☐ High blood pressure ☐ Macular degeneration

☐ Diabetes – Please give age of diagnosis _____

☐ Arthritis – Where are you affected? _____

☐ Coronary artery disease or heart disease ☐ Heart attack ☐ Stroke

☐ Other medical conditions _____

Surgical History – Please check all that apply.

☐ Adenoid removal ☐ Sinus surgery ☐ Tubes in ears ☐ Cataracts ☐ Tonsils

☐Gall bladder removal ☐ Hysterectomy ☐ Appendix removal ☐ Ovary removal

☐Joint replacement – Which joints? _____

☐ Other: _____ Blood type: _____

Family Medical History

Please check all the appropriate boxes for your family member if any of the following apply.

	Mother	Father	Grandmother	Grandfather	Siblings	Children
Heart disease	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐

If yes to cancer please list what type of cancer and what age it was found:

_____

_____

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Review of Systems - Please check all that apply to you.

Energy-activity
☐ Fatigue ☐ Weight gain ☐weight loss ☐ Put on weight easily ☐ Feel cold at temperatures that others are comfortable ☐ insomnia
☐Heat intolerance ☐ sweating ☐ fever ☐ night sweats
☐ Does going without food make you irritable or light headed? ☐ Yes ☐ No
Time of day you feel best _____ Worst _____
Amount of exercise per week _____

Eyes
☐ Blurred Vision ☐ Eye Irritation ☐ Vision Loss ☐ Corrective Lens ☐ Eye Pain ☐ Dry Eye
☐ Spots in Vision ☐ Double Vision ☐ Cataracts ☐ Macular Degeneration

Mouth, Throat, & Ears
☐ Ear Pain ☐ Stuffy Nose ☐ Canker Sores in mouth ☐ Hearing Loss ☐ Nose Bleeds ☐ Oral Lesions ☐ Tinnitus (ringing in ears) ☐ Post Nasal Drainage ☐ Hoarseness ☐ Vertigo ☐ Bleeding Gums ☐ Sore Throat ☐ Runny nose ☐ Dental Pain ☐ Mouth Breathing ☐ Bad breath ☐ Ear Infections ☐ Hay Fever ☐ Hearing Loss ☐ Dizziness ☐ Dental infections ☐ # of root canals _____ ☐ Silver fillings

Cardiovascular
☐ Chest Pain ☐Orthopnea ☐ Pain in thigh, calf, buttocks while walking ☐ Decreased exercise tolerance ☐ Heart Palpitations ☐Leg Ulcers ☐ Difficulty breathing during physical activity ☐ Fainting/passing out ☐ Edema ☐ Hypertension ☐ Rapid heartbeat ☐ Irregular heartbeat ☐Varicose veins ☐Snore while sleeping ☐Mitral valve prolapse ☐ Swollen feet

Lungs
☐ Cough ☐ Mucus Production ☐ Coughing up blood, bloody mucus ☐ Shortness of breath ☐ Wheezing ☐ Snoring ☐ Apneas ☐ Asthma ☐ Bronchitis ☐ Difficulty breathing ☐ Ever had a chest x-ray

Digestive Tract
☐ Abdominal Pain ☐ Bloating ☐ Belching ☐ Food intolerance ☐ Nausea ☐ Vomiting ☐ Swallowing Difficulties ☐ Reflux/Heart Burn ☐ Change in Bowel habits ☐ Constipation
☐ Diarrhea ☐ Black Stools ☐ Bloody Stools ☐ Poor sense of taste ☐ Hemorrhoids
Urinary tract/bladder

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☐ Change in Urinary Stream ☐ Painful Urination ☐ Blood in Urine ☐ Inability to control urination ☐ Urination at night ☐ Frequent Urination ☐ Urination Urgency ☐ Painful Intercourse ☐ Postmenopausal ☐ Low Libido ☐
Kidney/bladder infections

Joints/Muscles

☐ Joint pain ☐ loss of muscle ☐ Muscle cramps ☐muscle aches ☐ joint swelling

Skin

☐ Hair Changes ☐ Lesions ☐ Nail Changes ☐ Discoloration of skin ☐ itching skin ☐ Rash ☐ Cold hands ☐ Cold feet ☐ Dry Skin ☐ Hives ☐ Psoriasis ☐ Acne ☐ Loss of hair ☐ Facial puffiness in the mornings ☐ Weak/brittle nails ☐ Itching ☐ Dry, coarse brittle hair

Head

☐ Change in walking patterns ☐ Body weakness ☐ Headache- Where does it bother you? _____ ☐ Migraines How frequent? _____ ☐ Numbness ☐ Tremors ☐ Neck Injury ☐ Head injury ☐ Cannot think clearly/foggy thinking ☐ Poor focus

Emotions & Mind

☐ Anxiety ☐ Depression ☐ Irritability ☐ Decreased Concentration ☐ Panic Attacks ☐ Sleep Disturbances ☐ Sadness/tearfulness ☐ Mood Swings ☐ Unable to sit still ☐I am stressed out or easily confused ☐ Obsessive/compulsive thoughts

Hormone Axis

☐ Erectile dysfunction ☐ Tired constantly ☐ swollen testicles
☐ Low libido ☐ Fertility issues ☐ Tender breasts ☐ Gain weight easily

Sleep

☐ Difficulty Falling Asleep ☐ Difficulty staying asleep ☐ Snoring ☐ Restless Legs ☐ More tired after rest ☐ waking up Tired ☐ Gets tired easily ☐ Sleep light and restlessly ☐ Problems going back to sleep
Can you get a good night's sleep ☐ Yes ☐ No
When do you go to bed? _____ When do you wake up? _____

Hematologic/Lymphatic

☐ Bruising ☐ Bleeding Tendencies ☐ Swollen Lymph nodes ☐ Reoccurring Infections

Allergic/Immunologic

☐ Eczema ☐ Seasonal Allergies

Specific Health Questions - Please answer/explain as completely as possible.

How much do your drink daily? Coffee: _____ Soft drinks _____
How many diet drinks do you drink daily? _____

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Do you crave or over consume:
☐ Sugar (sweets) ☐ Chocolate ☐ Caffeine ☐ Alcohol
Vegetables per day (#)? ____

Chemical/Toxin Exposures:
☐Cigarette smoke ☐pesticides ☐ mold ☐ anti-perspirants
☐ Strong chemicals ☐ strong odors ☐ lead ☐PCBs ☐ Mercury ☐ ☐

Top Health Goals or Concerns you would like to focus on.

1._____
2._____
3._____