Dr. Kellie Raydon

Amrita: Nectar of Life

Online Clinic and Apothecary

Name_____Date_____

Preferred Name_____Gender _____ Pronoun Preference _____

Age_____Date of Birth_____Social Security #_____

Address_____City_____State_____Zip_____

Telephone—Home_____Work_____Cell_____

May we leave medical related information on your voicemail? Yes No

Email Address_____ May we contact you by email? Yes No

Occupation/Former Occupation _____ Full-time Part-time

Employer Name & Address_____

Married Separated Single Divorced Widowed Partnered

With whom do you live? Spouse/Partner Children Alone Parents Relatives Friends

Emergency Contact_____Relationship_____

Address_____

Telephone—Home_____Work_____Cell_____

How did you hear about us? Family/Friend Missoulian Independent Website Phone Book

If you were referred by someone, let us know who so we can thank them _____

Name of Primary Care provider: _____ Approx Date of Last visit _____

When, where and by whom did you last receive medical care?_____

_____

Primary reason for this visit _____

In your opinion, what are your most important physical, emotional, and/or mental health problems?

1._____

2._____

3._____

4._____

How do you rate your overall health? Excellent Good Fair Poor

What are you expectations for today's visit? _____

What are your expectations for our work together in general?_____

_____

Hospitalizations

What hospitalizations or surgeries have you had? When did they occur?

Special Studies

What diagnostic imaging studies have you had? (x-rays, CT scan, mammogram, MRI, bone density, EKG, EEG)

Medications, Supplements, Herbs

List all drugs, vitamins, herbs being taken at present with dosage

Are you allergic to any medications or other substances? Yes No

If yes, please list

Childhood Illnesses

Rubella (German 3 day measles) Measles (2 week) Mumps Chickenpox Roseola Whooping Cough

Polio Rheumatic Fever Scarlet Fever Asthma Eczema Frequent Ear Infections

Other?

Any difficulties with your birth or your mother's pregnancy with you?

Immunizations

Unsure, probably all of them Polio Pertussis Tetanus Diphtheria Measles/Mumps/Rubella

Other?

Your Health History

Current	Past		Current	Past	
		Allergies			Heart murmur
		Anemia			High blood pressure
		Arthritis			Injury--Serious
		Alcoholism			Kidney disease
		Bleeding problem			Liver disease
		Cancer			Overweight
		Candida			Pneumonia
		Colitis			Polio
		Drug/Alcohol Use			Rheumatoid Arthritis
		Eczema			Thyroid disorder
		Emphysema			Tuberculosis
		Headache			Sexually transmitted infection
		Head Injury			Other

Family History

My mother's health is: Good Fair Poor Deceased
My father's health is: Good Fair Poor Deceased

Has any **Blood Relative** had any of the following?

Yes	No	Unsure		Yes	No	Unsure	
			Anemia				Hay fever
			Arthritis				Heart attack
			Asthma				High blood pressure
			Bleeding disorder				Seizure disorder
			Cancer—Type				
			Diabetes				Sickle cell anemia
			Eczema				Thyroid disease
			Glaucoma				Tuberculosis
			Gout				

Social History

Have you traveled outside the USA?_____When/Where_____

Did you serve in the military? Yes No If yes, where/when_____

Do you have a religious or spiritual practice?_____

Overall stress level: Low Average High

In what areas of your life do you experience stress? Work Family Relationships Social Financial School

Please list the 4 most significant stressful events of your life, including childhood stressors.

1._____

2._____

3._____

4._____

Health Habits

Number of alcoholic drinks per week, on average: Non-drinker 0-1 1-5 5-10 10+

If so, what? Beer Wine Distilled

Do you use tobacco or have you used it in the past? Yes No If so, how many packs/tins per day _____

Total number of years tobacco use Total number of years since you stopped? _____

Circle any of the following that you do on a regular basis: Jog Walk Swim Bicycle Garden Hike Yoga Breathing exercises Stretching Weight Lifting Martial Arts Hunt Fish Other

How do you relax? _____

Primary Hobbies? _____

Sleep Patterns (circle): less than 6 hours 6-8 hours 8+ hours light sound can't fall asleep can't stay asleep

Diet

Number of meals eaten per day? 1 2 3 More than 3

How is your appetite? Good Poor Excessive

Who cooks the food you eat? _____

If you eat out, where do you go? _____

Any diet or food restrictions /special diets you follow? _____

List the foods **excluded** from your diet or the ones you avoid _____

_____

Amount of water you drink daily _____ Do you drink soda? What, diet/regular _____

Do you drink coffee/regular/decaf/how much? _____

What about your diet do you believe needs to be changed? _____

_____

Home Environment and Other Environmental Exposures

Circle any of the following that apply to your primary dwelling or life in general

Gas heat *Oil heat* *Wood Stove* *Electric heat* *Air Conditioning* *Electric Blanket* *TV*

Water quality? *Distilled* *Filtered* *Spring* *Well* *Deionized* *Ozonated* *Tap*

Do you have a *New Car* or *New Home*?

Do any of the following bother you? *Sunshine* *Loud noise* *Crowds* *Lack of sunshine* *Dampness* *Dryness* *Cold* *Heat* *Dust* *Mold* *Cat hair* *Dog hair* *Exhaust* *Fluorescent lighting* *Chemicals* *Perfumes*

Reproductive Health

Male

Are you currently sexually active? Yes Past, not currently

No Type of contraception used? _____Are you satisfied with your contraception? Yes No

Are you concerned about the possibility of a sexually transmitted infection? Yes No

Are you taking hormones of any kind? Yes No If yes, type and dose_____

Do you have any of the following? Testicular Pain Prostate Pain Hernia Penile Discharge Genital Sores

Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 (0=none)

Sexual function: Great, no complaints Starting to have troubles Erectile dysfunction

Female

Are you currently sexually active? Yes No Past, but not currently

Type of contraception used?_____Are you satisfied with your contraception? Yes No

Are you concerned about the possibility of a sexually transmitted infection? Yes No

Have you ever used—oral birth control pills Norplant Depo-Provera No to all of these options

Are you currently using—oral birth control pills Norplant Depo-Provera

Are you using hormone replacement therapy? Yes No If yes, type and dose_____

_____

Age when menstrual periods started _____Did you have a normal puberty?_____

You get your period every_____days. Regular cycles? Yes No

Your periods last_____ days, on average. Date of your last period_____Cramping Yes No Severe

Quality and quantity of flow—dark red, bright red, clots, very light, very heavy

Are you post menopausal (no period for 12 consecutive months)? Yes No Maybe

PMS Yes No Impacts my life every month

Approximate date of last PAP_____Have you ever had an abnormal PAP? Yes No When_____

Do you have any concerns about your ability to conceive? Yes No

Any chance you are pregnant now? Yes No Unsure

Number of pregnancies _____ Births_____ Miscarriages_____ Abortions _____

Any pregnancy complications? Yes No Briefly explain any complications_____

History of vaginal infections: Bacterial Vaginosis (BV) Yeast Chlamydia Gonorrhea Herpes HPV

Sexual desire 0 1 2 3 4 5 6 7 8 9 10 (0=none)

Sexual function: Great, no complaints Starting to have troubles Trouble

Any breast health concerns?_____

Date of last mammogram, if applicable: _____

Medical History: ***Please Circle*** **O** for Occasionally, **Y** for Yes, **P** for Past condition (not current); Leave the rest blank

General		**Mouth/Throat**		**Arms/Legs**	
Weight……		Frequent sore throat….	O Y P	Deep leg pain……	O Y P
Weight one year ago….		Sore tongue……	O Y P	Varicose veins……	O Y P
Maximum Weight……		Bleeding gums……	O Y P	Blood clots/thrombophlebitis	O Y P
When……		Gum disease……	O Y P	Nail fungus……	O Y P
Height……		Chronic hoarseness……	O Y P	Restless legs……	O Y P
Significant fatigue……	O Y P	Dental cavities……	O Y P	Pain with walking……	O Y P
Night sweats……	O Y P	Root canals……	O Y P		
History of cancer……	O Y P	Last dental exam……		**Gastrointestinal**	
Recent weight loss……	O Y P			Belching……	O Y P
Recent weight gain……	O Y P	**Respiratory/Lungs**		Gas……	O Y P
Fevers……	O Y P	Chronic cough……	O Y P	Gall bladder pain/removed	O Y P
Autoimmune illness….	O Y P	Chronic mucus……	O Y P	Heartburn/Reflux……	O Y P
Genetic condition……	O Y P	Coughing blood……	O Y P	Indigestion……	O Y P
Skin		Wheezing……	O Y P	Liver disease/problems……	O Y P
Recurrent Rashes……	O Y P	Asthma……	O Y P	Jaundice……	O Y P
Eczema……	O Y P	Bronchitis……	O Y P	Vomiting……	O Y P
Hives……	O Y P	Pneumonia……	O Y P	Blood in stool……	O Y P
Chronic Itching……	O Y P	Pleurisy……	O Y P	Hemorrhoids……	O Y P
Lumps……	O Y P	Emphysema……	O Y P	Binge eating……	O Y P
Head/Neck		Difficulty breathing……	O Y P	Abdominal/stomach cramps….	O Y P
Recurrent headaches..	O Y P	Pain with breathing……	O Y P	Constipation……	O Y P
Head Injury……	O Y P	Short of breath……	O Y P	Diarrhea……	O Y P
Swollen glands……	O Y P			# of bowel movements a day	#
Goiter……	O Y P	**Cardiovascular**			
Chronic pain/stiffness	O Y P	Heart disease……	O Y P	**Muscles/Bones/Joints**	O Y P
Whiplash……	O Y P	Angina/Chest pain……	O Y P	Joint pain/stiffness……	O Y P
Eyes		Hypertension……	O Y P	Arthritis……	O Y P
Eye pain……	O Y P	Murmurs……	O Y P	Muscle cramps……	O Y P
Tearing/dryness……	O Y P	Rheumatic fever……	O Y P	Weakness……	O Y P
Double vision……	O Y P	Ankles swelling……	O Y P	Frequent injury……	O Y P
Glaucoma……	O Y P	Skipped/ irregular beats	O Y P	Bone loss/Osteoporosis……	O Y P
Cataracts……	O Y P	Fainting……	O Y P		
Corrective lenses……	O Y P	High Cholesterol……	O Y P	**Nervous System**	
Ears				Seizures……	O Y P
Hearing loss……	O Y P	**Urinary**		Numbness /tingling……	O Y P
Ringing/tinnitus……	O Y P	Pain with urination……	O Y P	Memory loss……	O Y P
Earaches……	O Y P	Increased frequency……	O Y P	Balance problems……	O Y P
Chronic ear infections..	O Y P	Frequency at night……	O Y P		
Nose/Sinuses		Urgency/unable to hold.	O Y P	**Endocrine/Hormones**	
Frequent colds……	O Y P	Bladder/Kidney infections……	O Y P	Hypothyroid……	O Y P
Nose bleeds……	O Y P	Kidney stones……	O Y P	Hyperthyroid……	O Y P
Chronic Stuffiness……	O Y P			Low blood sugar……	O Y P
Hay fever……	O Y P	**Circulatory**		Diabetes……	O Y P
Sinus infections……	O Y P	Easy bruising……	O Y P	PCOS……	O Y P
Sinus surgeries……	O Y P	Anemia……	O Y P	Chilly, cold hands and feet……	O Y P
		Cold hands/feet……	O Y P	Hot and sweaty……	O Y P
				Metabolic Syndrome……	O Y P

Mood		**Reproductive-Female**		**Reproductive-Male**	
Panic Attacks……..	O Y P	Endometriosis……..	O Y P	BPH……	O Y P
ADD/ADHD……	O Y P	Breast Cancer……..	O Y P	Genital Warts……	O Y P
Anxiety……	O Y P	Fibrocystic Breasts……	O Y P	Lesions……	O Y P
Anger Issues……	O Y P	Fibroids……	O Y P	Erective Dysfunction……	O Y P
Bi-polar……..	O Y P	Genital Herpes……	O Y P	Prostatitis……	O Y P
Irritability……..	O Y P	Vaginal Dryness……	O Y P	Genital Herpes……	O Y P
Depression……..	O Y P	Hysterectomy……	O Y P	Low libido……	O Y P
Weepy……	O Y P	Infertility……	O Y P		
		Pain with intercourse…..	O Y P		
		Breast tenderness……	O Y P		
		Low libido……	O Y P		
		Ovarian cyst……	O Y P		

Health Insurance Information:

Insurance Co. Name _____ Phone _____

Address _____City _____ State _____Zip _____

I.D. # _____ Group# _____

Subscriber Name (If other than patient) _____ Date of Birth _____

Relationship to patient _____

Please Initial and Sign:

_____I authorize Dr. Kellie Raydon to examine and treat me virtually.

_____I understand that the treatments and therapies provided or recommended by this clinic may be different from those offered by another licensed health care provider, and that I am at liberty to seek other care as well.

_____I understand that payment is expected at the time of service.

_____If I choose to submit billings to my insurance company, I consent to the release of all information the insurance company may request for the filing of insurance claims.

Patient Signature_____Date_____

Responsible Party, if other than the patient_____Date_____