

**NEW ADULT PATIENT FORM**  
*Dr. Annette Hulse, 1 First St., Suite 3, Los Altos CA 94022*  
650-960-3485

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Referred by: \_\_\_\_\_

1. Current symptoms, problems, health concerns, and reason for visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Prescription medications: \_\_\_\_\_  
\_\_\_\_\_

3. Other medications (including over-the-counter meds, supplements, herbs, homeopathic remedies, etc.):  
\_\_\_\_\_  
\_\_\_\_\_

4. Allergies to medications: \_\_\_\_\_

5. Other allergies (foods, mold, pets, etc.): \_\_\_\_\_

6. Other food sensitivities: \_\_\_\_\_  
\_\_\_\_\_

7. Major medical problems (including illnesses, hospitalizations, surgeries, major dental work): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Describe any traumas, including car accidents, falls, head injuries, sports injuries, fractures (include year occurred): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Other therapies & treatments that you have used (past or present): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Describe your exercise routine or level of activity: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Birth History: Full-term    Premature    Late    C-Section    Force-ups/Vacuum    Vaginal Delivery (circle)  
Any complications? \_\_\_\_\_

# Older Siblings \_\_\_\_\_ # Younger Siblings \_\_\_\_\_

13. Did you have orthodontia? When? \_\_\_\_\_

**14. Past Medical History** (please check all that apply)

- |              |                          |                 |                          |                      |                          |
|--------------|--------------------------|-----------------|--------------------------|----------------------|--------------------------|
| Seizures     | <input type="checkbox"/> | Hives/Eczema    | <input type="checkbox"/> | Heart Disease        | <input type="checkbox"/> |
| Migraines    | <input type="checkbox"/> | Bronchitis      | <input type="checkbox"/> | High Blood Pressure  | <input type="checkbox"/> |
| Glaucoma     | <input type="checkbox"/> | Ear Tubes       | <input type="checkbox"/> | Low Blood Pressure   | <input type="checkbox"/> |
| Stroke       | <input type="checkbox"/> | Lyme Disease    | <input type="checkbox"/> | Arthritis            | <input type="checkbox"/> |
| Polio        | <input type="checkbox"/> | Hepatitis       | <input type="checkbox"/> | Bladder Infections   | <input type="checkbox"/> |
| Pneumonia    | <input type="checkbox"/> | Anemia          | <input type="checkbox"/> | Kidney Disease       | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | Ulcer           | <input type="checkbox"/> | Easy Bruising        | <input type="checkbox"/> |
| Cancer       | <input type="checkbox"/> | Diabetes        | <input type="checkbox"/> | Ulcer.colitis/Crohns | <input type="checkbox"/> |
| Asthma       | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | Meningitis           | <input type="checkbox"/> |

Other \_\_\_\_\_

15. Do you use:

- |                |                          |                    |                          |                     |                          |
|----------------|--------------------------|--------------------|--------------------------|---------------------|--------------------------|
| Glasses        | <input type="checkbox"/> | Dentures           | <input type="checkbox"/> | IUD/Diaphragm       | <input type="checkbox"/> |
| Contact lenses | <input type="checkbox"/> | Pacemaker          | <input type="checkbox"/> | Oral contraceptives | <input type="checkbox"/> |
| Hearing aid    | <input type="checkbox"/> | Neck or back brace | <input type="checkbox"/> |                     |                          |

16. Pregnancies: Total \_\_\_\_\_ Premature \_\_\_\_\_ Term \_\_\_\_\_ Abortions/Miscarriages \_\_\_\_\_ C/Sections \_\_\_\_\_

17. Last Dental Exam \_\_\_\_\_

18. Most Recent Routine Labs (Date/Result)

Vit D: \_\_\_\_\_ LH/FSH: \_\_\_\_\_  
 Thyroid Function (TSH/T4): \_\_\_\_\_ Testosterone: \_\_\_\_\_  
 Adrenal Function (Cortisol): \_\_\_\_\_

19. Other Exams (Date/Result)

- Food Sensitivity \_\_\_\_\_
- Saliva/Urine Hormone Testing \_\_\_\_\_
- Hair/Urine Heavy Metal \_\_\_\_\_
- Digestive Function/Stool Analysis \_\_\_\_\_
- Neurotransmitter Testing \_\_\_\_\_

20. Imaging (Date/Result)

X-ray \_\_\_\_\_  
 MRI \_\_\_\_\_  
 CT Scan \_\_\_\_\_  
 Ultrasound/Sonogram \_\_\_\_\_

21. Any other abnormal labs or tests? \_\_\_\_\_

22. Intake

Tobacco (type/amt. per week): \_\_\_\_\_ Alcohol (type/amt. per week): \_\_\_\_\_  
Caffeine (type/amt. per week): \_\_\_\_\_ Glasses water per day: \_\_\_\_\_  
Dietary restrictions/preferences: \_\_\_\_\_  
Sodas (# per week) - Diet or regular? \_\_\_\_\_

23. Sleep: How many hours of sleep do you average? \_\_\_\_\_  
Do you have trouble getting asleep? \_\_\_\_\_ Staying asleep? \_\_\_\_\_  
Do you take anything to help you sleep? \_\_\_\_\_ How many days/week? \_\_\_\_\_

24. Family History (please indicate relationship)

Cancer \_\_\_\_\_ Asthma \_\_\_\_\_  
Leukemia \_\_\_\_\_ Eczema \_\_\_\_\_  
Tuberculosis \_\_\_\_\_ Anemia \_\_\_\_\_  
Depression \_\_\_\_\_ Heart Disease \_\_\_\_\_  
Bipolar/Schizophrenia \_\_\_\_\_ Chronic Lung Disease \_\_\_\_\_  
Substance Abuse \_\_\_\_\_ Thyroid Disease \_\_\_\_\_  
Suicide \_\_\_\_\_ Kidney Disease \_\_\_\_\_  
Migraines \_\_\_\_\_ Hepatitis \_\_\_\_\_  
Seizures \_\_\_\_\_ Diabetes \_\_\_\_\_  
Allergies \_\_\_\_\_ Bleeding Tendency \_\_\_\_\_

25. List present age of family members, state of health (good, fair, poor), any major health problems. If deceased, list cause of death & age.

Father \_\_\_\_\_ Children \_\_\_\_\_  
Mother \_\_\_\_\_  
Sibling(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Spouse/partner \_\_\_\_\_

Review of Systems

26. Please mark any symptoms that you are having, or have experienced in the past year

- Weight gain
- Weight loss
- Change in appetite
- Persistent fever
- Hot flashes
- Night sweats
- Skin rash
- Change in nails/hair
- Easy bruises/bleeding
- Headaches
- Migraines
- Double vision
- Blurry vision
- Tinnitus
- Sinusitis
- Nasal congestion
- Mouth breathing
- Shortness of breath
- Chest pain
- Palpitations
- Restless legs
- Cold hands/feet
- Heartburn
- Bloating/belching
- Flatulence
- Constipation
- Diarrhea
- Hemorrhoids
- Abdominal pain
- Frequent urination
- Burning w/urination
- Urinary hesitancy
- Urinary urgency
- Heavy periods
- Premenstrual symptoms

27. Major Stressors in Your Life

- Personal health
- Job-related
- Financial
- Other \_\_\_\_\_
- Marriage
- Family stress
- Recent death of family/friends