

Magnolia Personalized Medicine P.C

[www.Magnoliapersonalizedmedicine.com](http://www.Magnoliapersonalizedmedicine.com)

*Dr. Wright*

6237342473

Which of the following treatments are you interested in?

- Natural aesthetics: facial lymphatics, light therapy, NAD+ cream
- Heavy metal and mold detox: oral
- Natural approach to autoimmune: Hashimoto, AK, MS, RA, ALS, Lupus, Psoriasis, Crohn disease
- Build up the immune system defense: Lymphatic drainage and liver detox
- Food sensitivity tests, hormone testing, candida testing, antioxidant testing
- Natural Weight loss programs with botanicals and lipotropics
- Hormonal balance with plants or bioidentical hormones
- Homeopathic: mild depression, sciatic pain, lymphatic drainage, hepatic detox
- Dr. Walsh protocol for mental health
- Specialized Testing for Allergies, nutritional Deficiencies, Cholesterol, GI Issues, etc.
- Natural treatments for digestive issues: ulcer, IBS, fatty liver
- Biotherapeutic drainage for joint pain, fatigue, degenerative disease, etc.
- Alternative to Mammogram= Thermography
- Personalized nutrients for adrenal fatigue, sleep, hypertension, cholesterol
- Mental health: stress, anxiety, focus, memory
- Nutritional therapy for Bipolar, OCD, ADHD, ADD, Depression, Anxiety, Addictions
- Nutrigenomics and Nutrigenetics testing
- Personalized diet: anti fatigue, anti-estrogenic, anti-inflammatory, DM2, gluten free

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Dr. Ellie Wright NMD**

**www.magnoliapersonalizedmedicine.com**

**MEDICAL INTAKE FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone: \_\_\_\_\_ (H) \_\_\_\_\_ (C) \_\_\_\_\_ (other)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F (circle one)

Email address: \_\_\_\_\_

How did you learn about *Magnolia Personalized Medicine*?

Already a Client  Advertisement \_\_\_\_\_  Website  Groupon

Web Search  Referred by: \_\_\_\_\_

Walk-In/Sign  Other: \_\_\_\_\_

In case of emergency, who should we contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**In the event that we cannot speak to you directly do you wish for us to leave medical information on your voicemail or message system?**

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what number may we leave medical information?

(c) \_\_\_\_\_ (h) \_\_\_\_\_ (w) \_\_\_\_\_

Do you wish to receive e-mails from our office?

Yes \_\_\_\_\_ No \_\_\_\_\_

Do you wish to receive text messages about appointment reminders?

Yes \_\_\_\_\_ No \_\_\_\_\_

**List, in order, of importance what your health concerns are:**

- 1.
- 2.
- 3.

**Current Medication & dose and supplements:**

- 1.
- 2.
- 3.
- 4.
- 5.

**Primary Physician name & contact info:**

**Diagnosis**

- 1.
- 2.
- 3.
- 4.

**List all surgeries & hospitalizations, including date occurred:**

- 1.
- 2.
- 3.

**Please note when & why you have had each of the following:**

X-Rays:

Accidents:

MRI/Cat Scans:

Ultrasounds:

TB Test: HCV: \_\_\_\_\_ HIV:

Last Dental Visit:

Last Eye Exam:

Did you have any of the follow Disease (D), Get Immunized (I), or Neither (N):

Measles: D I N Chicken Pox: D I N Mumps: D I N Rubella: D I N Tetanus: D I N Whooping Cough: D I N  
Hemophilus (Hib) D I N Hepatitis B: D I N German Measles: D I N

Did you receive Covid 19 vaccine?

Any vaccination reactions: \_\_\_\_\_

List Yes (Y), No (N), or Past (P) regarding use of the following:

Antacids: Y N P Steroids: Y N P Analgesics: Y N P Laxatives: Y N P

Smoking: Y N P Packs per day & number of years: \_\_\_\_\_

Coffee: Y N P Cups per day if Yes/Past: \_\_\_\_\_

Soda: Y N P Ounces per day if Yes/Past: \_\_\_\_\_

Alcohol: Y N P How often & how much if Yes/Past: \_\_\_\_\_

Any alcohol addiction: Y N P Any alcohol treatment: Y N P

Recreational drugs: Y N P Any drug addictions: Y N P

Any cancer treatment: Y N P

### **Review of Systems**

Present weight:

Weight one year ago:

Height:

Maximum weight & when:

Minimum weight & when:

Ideal weight:

### **Family History**

FATHER MOTHER SIBLINGS GRANDPARENTS SPOUSE CHILDREN

Parents Age, if living/died: \_\_\_\_\_

Siblings Age, if living/died: \_\_\_\_\_

Reason for death: \_\_\_\_\_  
\_\_\_\_\_

Cancer type: \_\_\_\_\_  
\_\_\_\_\_

Diabetes \_\_\_\_\_

Heart diseases \_\_\_\_\_

=====

### Medical History

**High Blood Pressure?** YES NO      **Heart Attack/Stroke?** YES NO      **Heart Disease?** YES NO  
**Asthma/Allergies?** YES NO      **Mental Illness?** YES NO      **TB?** YES NO      **Auto-Immune Disease?** YES NO  
**Diabetes Mellitus?** YES NO      **Osteoporosis?** YES NO

**REGARDING THIS NEXT SECTION: Please circle Yes (Y) if you have a problem NOW, circle Never (N) if you never had the problem, or (P) if you had the problem in the past.**

**Good Energy:** Y N P      **Fatigue:** Y N P      If you have fatigue, when is it the worst? (Morning, afternoon, evening )

If you have fatigue, can you do what you need to do during the day?

#### HEAD

**Headache:** Y N P      **Migraine:** Y N P      **Dandruff:** Y N P      **Head Injury:** Y N P  
**Oil/dry hair:** Y N P      **Hair loss:** Y N P

#### NOSE

**Frequent Colds:** Y N P      **Nosebleeds:** Y N P      **Congestion:** Y N P      **Post Nasal Drip:** Y N P  
**Polyyps:** Y N P      **Seasonal Allergies:** Y N P

#### EYES

**Dry/Watery:** Y N P      **Blurry Vision:** Y N P      **Double Vision:** Y N P      **Cataracts:** Y N P      **Glaucoma:** Y N P  
**Sties:** Y N P      **Strain:** Y N P      **Discharge:** Y N P      **Itchy:** Y N P      **Dark Circles** Y N P

#### MOUTH/THROAT

**Canker Sores:** Y N P      **Cold Sores:** Y N P      **Sore Throat:** Y N P      **Gum disease:** Y N P      **Dentures:** Y N P  
**Cavities:** Y N P      **Loss of taste:** Y N P      **Hoarseness:** Y N P

#### NECK

**Stiffness:** Y N P      **Swollen Glands:** Y N P      **Full Movement:** Y N P      **Tension:** Y N P

#### RESPIRATORY

**Cough:** Y N P      **TB:** Y N P      **Shortness of breath with exertion:** Y N P      **Bronchitis:** Y N P

**Shortness of breath sitting:** Y N P    **Pneumonia:** Y N P    **Shortness of breath while lying:** Y N P

**Asthma:** Y N P    **Wheezing:** Y N P    **Painful breathing:** Y N P

#### CARDIOVASCULAR

**High Blood Pressure:** Y N P    **Rheumatic Fever:** Y N P    **Low Blood Pressure:** Y N P    **Murmurs:** Y N P

**Arrhythmias:** Y N P    **Palpitations:** Y N P    **Edema:** Y N P    **Chest Pain:** Y N P

#### URINARY TRACT

**Incontinence:** Y N P    **Pain with Urination:** Y N P    **Frequent infections:** Y N P    **Kidney Stones:** Y N P

**Urgency:** Y N P    **Discharge/Blood:** Y N P

#### GASTROINTESTINAL

**Heartburn:** Y N P    **Bowel Movement Frequency:**    **Indigestion:** Y N P    **Recent BM Change:** Y N P

**Bloating:** Y N P    **Diarrhea/Constipation:** Y N P    **Nausea:** Y N P    **Hemorrhoids:** Y N P    **Vomiting:** Y N P

**Gall Bladder Disease:** Y N P    **Change in Appetite:** Y N P    **Liver Disease:** Y N P

**Pancreatitis:** Y N P    **Ulcer:** Y N P    **Rectal discharges/bleeding:** Y N P

#### MUSCULOSKELETAL

**Weakness:** Y N P    **Arthritis:** Y N P    **Stiffness:** Y N P    **Leg Cramps:** Y N P    **Tremors:** Y N P    **Pain:** Y N P

#### NERVOUS

**Paralysis:** Y N P    **Sciatica:** Y N P    **Tingling/numbness:** Y N P    **Carpal tunnel syndrome:** Y N P

**Seizures:** Y N P    **Fainting:** Y N P

#### MENTAL/EMOTIONAL

**Depression:** Y N P    **Anger/irritability:** Y N P    **Suicidal:** Y N P    **High-strung/tense:** Y N P

**Anxiety:** Y N P    **Fear/Panic:** Y N P    **Eating disorder:** Y N P    **Psych Hospitalization:** Y N P

#### MALE HEALTH

**Testicular pain/swelling:** Y N P    **Prostate Disease/Symptoms:** Y N P    **Hernia:** Y N P

**Sexually Active:** Y N P    **Discharge:** Y N P    **S.T.D.:** Y N P    **Impotency:** Y N P

**Sexual Orientation:** Heterosexual    Homosexual    Bisexual

#### FEMALE HEALTH

**Age began period:** \_\_\_\_\_ **How often period occurs:** \_\_\_\_\_

**How long period lasts:** \_\_\_\_\_ **Heavy menstrual bleeding:** Y N P

**Menstrual cramping:** Y N P      **Menstrual Pain:** Y N P

**PMS:** Y N P      **Food cravings:** Y N P

**Times Pregnant:** \_\_\_\_\_ **How many births** \_\_\_\_\_

**Miscarriages:** \_\_\_\_\_ **Abortions:** \_\_\_\_\_

**Last Pap Smear:** \_\_\_\_\_ **Diagnosis:** \_\_\_\_\_

**Any abnormal paps:** Y N P      **When was abnormal:** \_\_\_\_\_

**Menopausal since what age:** \_\_\_\_      **Use of hormones:** Y N P      **Types of hormones used:** \_\_\_\_\_

**Healthy libido:** Y N P      **Dry vagina:** Y N P      **Sexually Active:** Y N P      **Pain with intercourse:** Y N P

**Vaginitis:** Y N P      **S.T.D.:** Y N P      **Mammography:** Y N P      **Dexa Scan:** Y N P      **If Yes, what were results:**  
\_\_\_\_\_

**Sexual Orientation:** Heterosexual    Homosexual    Bisexual

**Please list any birth control used and ages used:**

#### EXERCISE

How often do you exercise?

What type of exercise?

For how long?

Hobbies:

#### SLEEP

**How long per night?** \_\_\_\_\_      If you wake up frequently, what is the reason? \_\_\_\_\_

**Nightmares:** Y N P      **Wake Refreshed:** Y N P      **Must nap during the day:** Y N P

**Sleep walk:** Y N P      **Grind teeth:** Y N P      **Snore** Y N P

#### TOXIN EXPOSURE

- Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?
- Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials?
- Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing?
- Are you particularly sensitive to perfumes, gasoline or other vapors?
- Do you use pesticides, herbicides or other chemicals around your home?

#### SOCIAL LIFE

Do you enjoy your job? Y N P      Hours worked per week:      Highest level of education:

Active spiritual practice: Y N P

Quality of significant relationship:

History of sexual, mental/emotional, physical abuse: Y N P If so, at what age and by whom:

What is your greatest health concern:

How does it limit you the most:

How committed are you toward making valuable changes? Little Moderately Very

#### **TYPICAL DAY'S DIET**

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

#### **ALLERGIES**

**List all known allergies:**

Food:

Drugs:

Environment:

***I give my consent for examination, treatment and testing by Dr. Ellie Wright at Magnolia Personalized Medicine. Please, sign below that this information is true and correct.***

**Signature/ Date:**

**Patient or Guardian Signature/ Date:**