Magnolia Personalized Medicine P.C

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:

1.

2.

3.

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:

<u>X-Rays:</u>

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_____ _____

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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 your 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 **Polyps**: 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: