

Annie Rafter, RNC, CNP/Imana Medicine

Legal Name: _____
Preferred Name: _____
Address: _____
City : _____
Home Phone: _____ Work _____
Mobile Phone:() _____
Date of Birth: _____ Age: _____

Date: _____
E-Mail: _____
SS #: _____
State/Zip: _____
Insurance Co: _____
Occupation: _____
Referred by: _____

Social History

Are you in a committed relationship? [] Yes [] No
Are you Married [] Yes [] No
Cigarettes per day? _____ Now _____ Past
Do you use recreational drugs? [] Yes [] No
What routine exercise do you do? _____
Are you under a lot of stress? _____
Describe your diet in general: _____

Name of Partner: _____
Partner Phone#: _____
Alcohol (amount per wk.) _____
Coffee(cups per wk.) _____ Tea _____
What is the source? _____

Medical History

- Alcoholism, Asthma, Blood Clots, Blood Trans., Cancer, Chicken Pox, Diabetes, Eczema, Gastric Problems, Glaucoma, Headaches, Heart Disease, Hepatitis, High Blood Pressure, Kidney Disease, Lung Disease, Measles, Mental Health Issues, Migraines, Pneumonia, Scarlet Fever, Seizures, Stroke, TB, Thyroid Problems, Ulcers, Urinary Infections, Vein Problems

Any Serious or chronic problems? _____

Any Drug Reactions/Allergies: _____

List Medications, Vitamins, Herbs you are now taking and amounts: _____

List Hospitalizations, operations and include reason(s) and dates(s): _____

Have you had a prostate exam? [] Y [] N _____ date

Have you ever been exposed to incest, rape, or other sexual abuse [] Yes [] No

In the last year, have you been threatened or experienced any kind of violence? [] Yes [] No

Have you ever had:

- Difficulty Starting/Maintaining Urine Flow, Erectile Dysfunction, Urinary Frequency, Testicular Cancer, Testicular or Scrotal Inflammation/Pain, Elevated PSA, Enlarged Prostate

Are you currently being treated for any of the above? _____

Family History

- Alcoholism, Alzheimer's, Arthritis, Asthma, Birth Defects, Bleeding Disorders, Cancer, Diabetes, Epilepsy, Gall Bladder, Genetic Disorders, Glaucoma, Gout, Heart Disease, High Blood Pressure, Other, Kidney Disease, Mental Illness, Migraines, Osteoporosis, Stroke, TB, Thyroid Disease

Do you have any other concerns that you have not mentioned on this form?

