True Health Medical Center

Adult New Patient Screening Form

Please complete the entire form and send it to our office.

1. **Patient's Name**: _____ **DOB:**_____ **Sex**: ***M F***
   Phone: _____
   State/Country: _____ _____
   Email: _____

2. ***Chief complaint or reason for seeking an appointment:***

_____
_____
_____
_____
_____
_____
_____

3. ***Do you have a history of any of the following:***

- ☐ **Auto-Immune Disease**
- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **Hypertension**
- ☐ **Kidney Disease**
- ☐ **Lyme Disease**
- ☐ **Seizure Disorder**
- ☐ **Stroke**
- ☐ **Other Chronic Medical Conditions**

Please comment on any illnesses marked above:_____
_____
_____
_____
_____

4. ***Do you have any other medical issues, major surgeries, or hospitalizations? If so, please describe:*** _____
_____
_____
_____
_____

5. ***Do you have a primary care physician? Y N***

6. ***What medications and supplements do you currently take?***

_____
_____
_____
_____
_____

7. ***Do you speak English? Y N If not, will you have an interpreter available for all consultations?***
   _____
   _____

Note: This information is for screening purposes only. It is not part of any medical record and will not be kept on file.