University of California
San Francisco

UCSF

Osher Center for
Integrative Medicine

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NEW PATIENT INFORMATION FORM

Last Name _____ First Name _____

Preferred Pronoun _____ Date of Birth_____ Today's Date _____

Are you an existing UCSF Patient? ☐ Yes ☐ No Insurance Carrier _____

CONTACT INFORMATION

Address_____

City _____ State _____ Zip _____

Preferred Contact Number: _____
(*Where can we leave you a message?)*

Home: _____ Work: _____

Email Address _____

EMERGENCY CONTACT

Last Name _____ First Name _____

Relation _____ Telephone _____

Address _____

City _____ State _____Zip _____

TREATMENT TEAM

Primary Care Provider (PCP) _____ Date of last visit with PCP: _____

Please list all members of your care team (including integrative/complementary health practitioners):

_____

_____

_____

What services are you interested in?

- ☐ Integrative Ayurveda
- ☐ Integrative Biofeedback
- ☐ Integrative Chinese Medicine & Acupuncture
- ☐ Integrative Manual Medicine
- ☐ Integrative Massage Therapy
- ☐ Integrative Medicine
- ☐ Integrative Nutrition
- ☐ Integrative Oncology
- ☐ Integrative Psychiatry & Psychotherapy
- ☐ Integrative Women's Health

PATIENT NAME

BIRTHDATE

DATE OF SERVICE

1. What are your primary health concerns and goals for this visit?

2. Please describe your prior experiences with Integrative Medicine:

3. What are major stressors in your life?

4. What helps you cope with stress?

5. Please describe your sleeping patterns:

6. Please describe your interests and hobbies:

7. Please describe your support system (for example: family, friends, spirituality, community, groups, pets):

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NUTRITION & EXERCISE

Please describe your typical diet:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Do you follow any special diet? ☐Yes ☐No *If yes, please describe:* _____

How many glasses of fluids (water, juice) do you drink a day? _____

How many cups/cans of caffeinated drinks (coffee, tea, soda) do you drink/day? _____

Do you have concerns about your nutrition? ☐Yes ☐No *If yes, please describe*:_____

Do you change your eating habits when you are upset, worried, or sad? ☐Yes ☐No

Do you eat when you are rushed? ☐Yes ☐No

Do you skip meals? ☐Yes ☐No ☐Breakfast ☐Lunch ☐Dinner

Do you exercise regularly? ☐Yes ☐No *If yes, please describe*:

_____

PAST MEDICAL HISTORY

Please check Yes or No for any illnesses that you have had: ☐UCSF MyChart is up to date (within this year)

Anemia	☐Yes	☐No	Hepatitis	☐Yes	☐No
Arthritis	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Asthma / Bronchitis / Emphysema	☐Yes	☐No	Immune Disorders	☐Yes	☐No
Bleeding / Bruising	☐Yes	☐No	Intestinal Problems	☐Yes	☐No
Blood Disorder	☐Yes	☐No	Kidney Disease	☐Yes	☐No
Cancer (*type*):	☐Yes	☐No	Liver Disease	☐Yes	☐No
Depression / Emotional Problems	☐Yes	☐No	Lung Disease	☐Yes	☐No
Diabetes	☐Yes	☐No	Skin Disease	☐Yes	☐No
Drug / Alcohol Dependency	☐Yes	☐No	Stroke	☐Yes	☐No
Epilepsy / Seizures	☐Yes	☐No	Stomach Ulcers	☐Yes	☐No
Hay Fever / Sinus Problems	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Heart Problems	☐Yes	☐No	Other (*describe*):	☐Yes	☐No

Have you ever been hospitalized? ☐Yes ☐No

If yes, please list the date(s) and reason(s): ☐UCSF MyChart is up to date (within this year)

_____

_____

Have you had any surgeries? ☐Yes ☐No

If yes, please list the date(s) and type(s) of surgeries: ☐UCSF MyChart is up to date (within this year)

_____

_____

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FAMILY HISTORY

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Have any family members (including grandparents, parents, siblings, and children) had any of the following?

Illness	Check Yes or No		Family Relationship
Alcoholism / Substance Abuse	☐ Yes	☐ No	
ALS (Lou Gehrig's Disease)	☐ Yes	☐ No	
Alzheimer's / Dementia	☐ Yes	☐ No	
Anemia / Bleeding Problems	☐ Yes	☐ No	
Cancer (Breast, Ovarian, Colon, Other)	☐ Yes	☐ No	
Depression / Other Mental Illness	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Heart Disease / Angina	☐ Yes	☐ No	
Hepatitis / Liver Disease	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
High Cholesterol	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	
Osteoporosis	☐ Yes	☐ No	
Seizure Disorders	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Thyroid Disease	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Other (please describe):	☐ Yes	☐ No	

Do you take any medications (prescription drugs, over-the-counter drugs, and supplements)?

☐ Yes ☐ No *If yes, please list below*

☐ UCSF MyChart is up to date (within this year)

Name of Medication, Supplement, or Herb	Dose or Strength	How often do you take it?

Do you have any allergies?

☐ Yes ☐ No *If yes, please list below*

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Allergen (medication, environmental, substance)	Reaction

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PREVENTIVE CARE

☐ UCSF MyChart is up to date (within this year)

Have you received a vaccine to prevent any of the following diseases? *If yes, please provide date.*			
Tetanus (DT)	○ No	○ Yes	Date:
Influenza (flu)	○ No	○ Yes	Date:
Pneumonia	○ No	○ Yes	Date:
Hepatitis B	○ No	○ Yes	Date:
Rubella / MMR	○ No	○ Yes	Date:

Have you ever had any of these screening tests done? *If yes, please provide date of last test.*			
Cholesterol	○ No	○ Yes	Date:
Hemoglobin A1C	○ No	○ Yes	Date:
Stool test for blood	○ No	○ Yes	Date:
Sigmoidoscopy or Colonoscopy	○ No	○ Yes	Date:
Bone density scan	○ No	○ Yes	Date:

PAIN

Do you suffer from pain? ☐ Yes ☐ No *If yes, please answer the questions in the box below:*

Where is the pain?_____ What does the pain feel like? _____

Does the pain limit your activity or interfere with your sleep & emotional well-being?
If yes, please describe: _____

Please select a number from 0-10 that best describes how much pain you are having now:

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Pain — Worst Pain Possible

What makes the pain worse? _____

What makes the pain better? _____

Please list any medication(s) or other type(s) of treatment you use for pain relief:

_____

_____

FUNCTIONAL STATUS

Have you experienced any change in your ability to do your usual activities? ☐ Yes ☐ No

Are you receiving any special help at home? ☐ Yes ☐ No

Have you had 3 or more falls in the past year? ☐ Yes ☐ No

Do you have any difficulty bathing or dressing yourself? ☐ Yes ☐ No

Do you ever lose control over your urination or bowel movements? ☐ Yes ☐ No

Do you have an Advance Health Care Directive/Living Will/Durable Power of Attorney? ☐ Yes ☐ No ☐ Unsure

If no, would you like information about Advance Directives? ☐ Yes ☐ No ☐ Unsure

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SOCIAL HISTORY

Please tell us about your lifestyle and personal habits:

What is your occupation? _____

Are you retired? ☐ Yes ☐ No

Marital Status (Check One) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Do you live alone? ☐ Yes ☐ No *If no, who do you live with?* _____

Do you use any tobacco products? ☐ Yes ☐ No *If yes, please answer the following questions:*

How many packs of cigarettes per day? _____ How many years? _____ Quit Date? _____

Do you drink alcohol? ☐ Yes ☐ No *If yes, please answer the following questions*:

During the last week, on how many days have you had a drink? _____

On days when you had a drink, how many drinks (beer, wine, or liquor) did you have? _____

Do you have any concerns about your alcohol use? ☐ Yes ☐ No

Do you take any recreational substances such as cannabis, cocaine, stimulants, or opioids? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever injected any substance? ☐ Yes ☐ No

In the last 12 months, have you been hurt or felt threatened by someone close to you? ☐ Yes ☐ No

During the past month, have you felt “down” or depressed? ☐ Yes ☐ No

Do you have trouble finding pleasure in things you used to enjoy? ☐ Yes ☐ No

Have you ever been so sad that you thought about harming yourself? ☐ Yes ☐ No

Do you have any concerns about your sexual health? ☐ Yes ☐ No

Have you had sex with men? ☐ Yes ☐ No

Have you had sex with women? ☐ Yes ☐ No

Have you had sex with non-binary partners? ☐ Yes ☐ No

Do you and your sexual partner(s) practice safe sex? ☐ Yes ☐ No ☐ Unsure

Please answer the following questions if applicable:	Yes	No	Additional information
Have you ever had a mammogram? *(If yes, please give date, results of last mammogram, & where it was done)*	☐	☐	
Have you ever had an abnormal mammogram? *(If yes, please give date, results, and treatment)*	☐	☐	
Do you routinely practice self-breast exams?	☐	☐	
When was your last PAP smear?	☐	☐	
Have you ever had an abnormal PAP smear? If yes, please give date, results, and treatment	☐	☐	

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Please answer the following questions if applicable:	Yes	No	Additional information
Do you have problems with any of the following?	☐	☐	
Urinary frequency / urgency frequent urination at night	☐	☐	
Lack of bladder control / incontinence painful urination	☐	☐	
Blood in urine	☐	☐	
Recurrent urinary tract infections vaginal discharge	☐	☐	
Vaginal pain / itching / irritation vaginal dryness	☐	☐	
Hot flashes	☐	☐	
Change in sex drive	☐	☐	
Bleeding between periods / after menopause	☐	☐	
How old were you when you had your first menstrual period?			
Do you still have menstrual periods?	☐	☐	
If you are still having periods, on what day did your last period start?			
Are your periods regular?	☐	☐	
Are your periods painful?	☐	☐	
How many days are there between periods?			
How long does your period last?			
How would you describe your periods?			
Have you ever been on hormone replacement therapy? *If yes, give dates & type:*	☐	☐	
Have you ever been pregnant? *If yes, please write-in total number of pregnancies, deliveries, miscarriages, and abortions:*	☐	☐	
Did you have complications with a pregnancy? *If yes, please describe:*	☐	☐	
Do you currently use any form of birth control? *If yes, please state type used:*	☐	☐	
Have you had problems with: ☐ testicular pain ☐ impotence / change in sexual function ☐ prostate problems ☐ urinary problems: ☐ difficulty starting stream urinary frequency ☐ frequent urination at night ☐ lack of bladder control / dribbling painful urination ☐ blood in urine ☐ recurrent urinary tract infections			
Have you ever had a sexually transmitted disease? *If yes, please describe:*	☐	☐	
Have you ever been screened for prostate cancer? *If yes, was it a digital rectal exam?*	☐ ☐	☐ ☐	
Do you routinely practice testicular self-exams?	☐	☐	

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REVIEW OF SYSTEMS

Have you experienced any of the following in the past 3-6 months?
Please check if yes

- ☐ Change in general health
- ☐ Recent weight changes
- ☐ Recurrent fevers, chills, or sweats
- ☐ Heat or cold intolerance
- ☐ Extreme fatigue
- ☐ Change in appetite
- ☐ Excess thirst or urination
- ☐ Difficulty sleeping

- ☐ Wear glasses or contact lenses
- ☐ Change in vision
- ☐ Pain or irritation in eye(s)
- ☐ Redness or discharge from eye(s)

- ☐ Change in hearing or ringing in ears
- ☐ Recent nose bleeds
- ☐ Chronic sinus problems or runny nose
- ☐ Allergy symptoms
- ☐ Voice changes
- ☐ Recurrent sore throat
- ☐ Difficulty swallowing

- ☐ Breathing problems
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Coughing-up blood

- ☐ Chest pain or angina
- ☐ Irregular heart rhythm or palpitations
- ☐ Swelling of feet, ankles, hands

- ☐ Severe heartburn
- ☐ Nausea or vomiting blood
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Frequent diarrhea
- ☐ Black or bloody stools

- ☐ Easy bruising
- ☐ Frequent or prolonged bleeding
- ☐ Enlarged lymph nodes
- ☐ Decreased resistance to infection

- ☐ Breast pain
- ☐ Breast lump or swelling

- ☐ Joint or muscle stiffness
- ☐ Neck pain or back pain
- ☐ Weakness
- ☐ Difficulty walking

- ☐ Headaches
- ☐ Numbness or tingling sensation
- ☐ Weakness or paralysis
- ☐ Convulsions or seizures

- ☐ Nervousness or anxiety
- ☐ Sadness or depression
- ☐ Special messages only you receive
- ☐ Visions or voices only you perceive

- ☐ Unusual rash or skin problems
- ☐ Delayed healing
- ☐ Change in hair or nails

Is there anything else you would like to discuss or want our team to know?

_____

_____

_____

Signature / Printed Name _____ Date _____