UCSF Osher Center for Integrative Health

**New patients must submit this completed form no later than one week before the first visit**
**Email: OsherNP@ucsf.edu | Fax: (415) 353-7358 | Phone: (415) 353-7700.**

**Name:** _____

**Date of Birth:** _____

## SECTION I: INTEGRATIVE HEALTH CONSULTATION

What are your primary goals for this visit?

_____

_____

Please describe your prior experiences with Integrative Health:

_____

_____

_____

### A. TREATMENT TEAM

Primary Care Provider (PCP) _____Preferred Lab: ☐UCSF ☐LabCorp ☐Quest

Please list all members of your care team: _____

_____

_____

_____

**Integrative Clinical Services and Group Medical Visits**

Osher Center clinicians are trained in both biomedical and complementary medicine. To learn more about our practitioners and treatments, visit: https://osher.ucsf.edu/patient-care/clinical-specialties

### B. FOUNDATIONAL PRACTICES: Nourish, Move, Rest, Reflect

Do you follow any specific diet or fast? ☐Yes ☐No *If yes, please describe:*

_____

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

**Please describe your typical diet**:

| | Time | |
|---|---|---|
| Breakfast | | |
| Lunch | | |
| Dinner | | |
| Snacks | | |

**Approximately how many cups of the following fluids do you typically drink each day?**

| Water | Juice/Other *Note type* | Caffeinated drinks *Note type (coffee, tea, etc.)* | Soda *Note type (diet, regular)* |
|---|---|---|---|
| | | | |

**Please describe your physical activity, exercise, or movement, and time spent per week:**

| Light Activity *(e.g., walking, stretching)* | Aerobic-Moderate *(i.e., light sweating)* | Aerobic-Vigorous/High *(i.e., sweating, faster heart rate)* | Strengthening exercises *(e.g., yoga, weight training)* | Balance exercises |
|---|---|---|---|---|
| | | | | |

**Please describe your sleeping patterns:**

_____

_____

**Are you interested in mind-body practices** (e.g., mindfulness, meditation, yoga )? ☐ Yes ☐ No
*If yes, please describe*:

_____

_____

To learn more about courses for mind-body wellbeing, please visit: https://osher.ucsf.edu/public-classes

## C. MEDICATIONS AND SUPPLEMENTS: Prescription, Over-the-counter, Botanicals

*Please list below. If a more convenient option, please feel free to attach a separate list or take photos.*

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

Do you take cannabis or marijuana? ☐ Yes ☐ No *If yes, please describe the forms/effects on you:*

_____

## D. MIND-BODY HEALTH AND WELL-BEING

**Do you experience physical or emotional pain?** ☐ Yes ☐ No *If yes, please answer the following:*

Circle a number from 0-10 that best describes how much pain you are having today:

No Pain ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 Worst Pain

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

_____

What makes the pain worse? What makes the pain better?

_____

Please list any medications or supplements you take for pain relief:

_____

_____

Please check or list any treatments you have tried for pain relief:

☐ Acupuncture ☐ Physical Therapy ☐ Injections (*e.g., prolotherapy, epidurals, facet, nerve blocks, radiofrequency ablation), ☐ Other _____

How does pain impact your daily activities, sleep, or emotional well-being?

_____

In the last 12 months, have you been hurt or threatened? ☐ 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

**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
Would you like information about Advance Directives? ☐Yes ☐No ☐ Unsure

**Substance history** *If yes for any of the following, please complete additional questions:*

Do you drink alcohol? ☐Yes ☐No
*During the last week, 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 tobacco products? ☐Yes ☐No
*What form(s)? ☐ cigarettes ☐ vape ☐ gum ☐ patch. How many times in a day?☐*
*How many years? _____ Quit date? _____ How many packs of cigarettes per day? _____*
Have you been exposed to second-hand smoke? ☐Yes ☐No
Have you ever injected any substance? ☐Yes ☐No
Have you ever taken cocaine, stimulants, opioids, or other substance? ☐Yes ☐No
*If yes, please describe:* _____

## E. SOCIAL AND CULTURAL HISTORY

What is your employment status? ☐Full-time ☐Part-time ☐Unemployed ☐Retired ☐Other
What is/was your occupation?_____
Do you live alone? ☐Yes ☐No *If no, who do you live with?*_____
Relationship Status:☐Single ☐Married ☐Divorced ☐Widowed ☐Partnered ☐Prefer no answer

What are the major stressors in your life?

---

What helps you cope with stress?

---

Please describe your interests and hobbies:

---

Please describe your support system (e.g., family, friends, community, groups, pets):

---

Do you have any cultural, religious practices, or spiritual beliefs you would like to share with us?

---

Please share how you and/or your family/caregiver learn best (e.g. written, visual, audio, etc.)?

---

## F. REVIEW OF SYSTEMS

***Please check if you have experienced any of the following in the past 3-6 months:***

| | |
|---|---|
| ☐ Abdominal pain | ☐ Heartburn |
| ☐ Allergy symptoms | ☐ Heat or cold intolerance |
| ☐ Appetite changes | ☐ Joint or muscle stiffness |
| ☐ Black or bloody stools | ☐ Infections (recurrent or possible) |
| ☐ Breast pain, lump, or swelling | ☐ Memory or concentration changes |
| ☐ Breathing problems | ☐ Nausea or vomiting |
| ☐ Bruising or bleeding easily or frequently | ☐ Nervousness or anxiety |
| ☐ Changes in general health | ☐ Numbness or tingling |
| ☐ Chest pain | ☐ Pain in neck or back |
| ☐ Chronic cough | ☐ Palpitations |
| ☐ Chronic sinus problems or runny nose | ☐ Sadness or depression |
| ☐ Confusion, convulsions, seizures, or blackouts | ☐ Shortness of breath |
| ☐ Constipation | ☐ Sleep difficulties |
| ☐ Coughing-up blood | ☐ Sore throat |
| ☐ Diarrhea | ☐ Special messages, visions, or voices |
| ☐ Dizziness or lightheadedness | ☐ Swallowing difficulties |
| ☐ Excessive stress | ☐ Swelling of feet, ankles, hands |
| ☐ Excessive thirst or urination | ☐ Toxic exposure (e.g., mold, pesticides) |
| ☐ Eyes: pain, irritation, redness, or discharge | ☐ Unusual rash or skin problems |
| ☐ Fatigue | ☐ Visual changes |
| ☐ Fevers, chills, or sweats | ☐ Vocal changes |
| ☐ Hair or nail changes | ☐ Walking difficulties |
| ☐ Headaches | ☐ Weakness or paralysis |
| ☐ Hearing changes or ringing in ears | ☐ Weight changes |

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

**SECTION II: If your MyChart/CareEverywhere records are not current, please answer the following:**

**PAST MEDICAL HISTORY**. *Please **Check** Yes or No for any illnesses you have had:*

| | | | | | |
|---|---|---|---|---|---|
| Anemia | ☐Yes | ☐No | Hepatitis | ☐Yes | ☐No |
| Arthritis | ☐Yes | ☐No | High Blood Pressure | ☐Yes | ☐No |
| Asthma, Bronchitis, or Emphysema | ☐Yes | ☐No | Immune Condtions | ☐Yes | ☐No |
| Bleeding or Bruising | ☐Yes | ☐No | Intestinal Conditions | ☐Yes | ☐No |
| Blood Disorder | ☐Yes | ☐No | Kidney Condition | ☐Yes | ☐No |
| Cancer (type): | ☐Yes | ☐No | Liver Condition | ☐Yes | ☐No |
| Depression or Anxiety | ☐Yes | ☐No | Lung Condition | ☐Yes | ☐No |
| Diabetes | ☐Yes | ☐No | Skin Condition | ☐Yes | ☐No |
| Epilepsy or Seizures | ☐Yes | ☐No | Stroke | ☐Yes | ☐No |
| Hay Fever or Sinus Conditions | ☐Yes | ☐No | Stomach Ulcers | ☐Yes | ☐No |
| Heart Condition | ☐Yes | ☐No | Thyroid Condition | ☐Yes | ☐No |

*If the condition(s) is not listed, please describe: _____

_____

**Have you ever been hospitalized?** ☐ Yes ☐ No *If yes, please list the date(s) and reason(s):*

_____

_____

_____

**Have you had any surgeries?** ☐ Yes ☐ No *If yes, please list the date(s) and type(s) of surgeries:*

_____

_____

_____

**Do you have any allergies?** ☐ Yes ☐ No *If yes, please list below:*

| **Allergen:** *medication, environmental, substance* | **Reaction** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Please answer any of the following questions if applicable to you:**

| **Sexual Health** | *Additional information* |
|---|---|
| Do you have any concerns about your sexual health? ☐ Yes ☐ No | |
| Have you had sex with women? ☐ Yes ☐ No | |
| Have you had sex with men? ☐ 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 | |
| Have you ever had a sexually transmitted disease? ☐ Yes ☐ No ☐ Unsure | |

| **Women's Health** | *Additional information* |
|---|---|
| Do you have problems with any of the following? *If yes, please check*<br>☐ Urinary frequency, urgency, urination at night<br>☐ Lack of bladder control, incontinence, or painful urination<br>☐ Blood in urine<br>☐ Recurrent urinary tract infections, or vaginal discharge<br>☐ Vaginal pain, itching, irritation, or vaginal dryness<br>☐ Hot flashes<br>☐ Change in sex drive<br>☐ Bleeding between periods or after menopause | |
| Have you ever had a mammogram? ☐ Yes ☐ No<br>*If yes, note date, results, and where it was done:* | |
| Have you ever had an abnormal mammogram? ☐ Yes ☐ No<br>*If yes, note date, results, and treatment:* | |
| Do you routinely practice self-breast exams? ☐ Yes ☐ No | |
| When was your last PAP smear? ☐ Yes ☐ No | |
| Have you ever had an abnormal PAP smear? ☐ Yes ☐ No<br>*If yes, note date, results, treatment* | |
| How old were you when you had your first menstrual period? Age ____ | |
| Do you still have menstrual periods? ☐ Yes ☐ No | |
| *If you are still having periods, on what day did last period start? ___/___/___* | |
| *Are your periods regular?* ☐ Yes ☐ No | |
| *Are your periods painful?* ☐ Yes ☐ No | |
| *How many days are there between periods? ____ days* | |
| *How long does your period last? ____ days* | |
| *How would you describe your periods?* | |
| Have you ever been on hormone replacement therapy? ☐ Yes ☐ No<br>*If yes, note dates and type:* | |
| Have you ever been pregnant? ☐ Yes ☐ No<br>*Write the total number of pregnancies, deliveries, miscarriages, abortions:*<br>*Did you have complications with a pregnancy?* ☐ Yes ☐ No | |
| Do you currently use any form of birth control? ☐ Yes ☐ No | |

| **Men's Health** | *Additional information* |
|---|---|
| Have you had problems with the following. *If yes, please check:*<br>☐ Testicular pain<br>☐ Impotence / change in sexual function<br>☐ Prostate problems<br>☐ Difficulty starting stream urinary frequency<br>☐ Frequent urination at night<br>☐ Lack of bladder control, dribbling, or painful urination<br>☐ Blood in urine<br>☐ Recurrent urinary tract infections | |
| Do you routinely practice testicular self-exams? ☐ Yes ☐ No | |
| Have you had a PSA blood test? ☐ Yes ☐ No | |
| Have you ever been screened for prostate cancer? ☐ Yes ☐ No<br>*Was it a digital rectal exam?* ☐ Yes ☐ No | |