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NEW ADULT PATIENT HISTORY

To our new patients: *Welcome* to the Integra Medical Center, the integrative medical practice of Dr. Omar D. Gonzalez administering advanced Stem Cell Therapy, Acupuncture, and other methods. Please complete the health history below in detail so we may effectively treat your condition and maximize the result of your treatment. PLEASE PRINT LEGIBLY AND IN INK.

Personal History

Name: _____ Date of Birth ___ / ___ / ___ Age ___ Date: _____
Occupation _____ Birthplace _____
Your Doctor: _____ Referred by: _____
Phone numbers: Home _____ Office _____
Email address _____

Allergies:

Main Problem / Reason For This Appointment: (if possible, rank in terms of importance to you)

1. _____
2. _____
3. _____
4. _____
5. _____

Additional problems or concerns you would like addressed:

Current Medications	List Any Current Side Effects	Dose	Times / Day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Herbs / Vitamins / Supplements	Dose	Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical, Surgical & Trauma History:

Patient Name:

List prior illness, injury, hospitalization, surgery, and/or trauma:

Reason:

Date:

Personal and Family History:

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

Social History: (check those that apply): **Patient Name:**

Marital status:	Education level completed:	Memories of your childhood:	You find your Life:
<input type="checkbox"/> Single	<input type="checkbox"/> High School	<input type="checkbox"/> Mostly Happy	<input type="checkbox"/> Generally Unsatisfactory
<input type="checkbox"/> Married	<input type="checkbox"/> College	<input type="checkbox"/> Mostly Painful	<input type="checkbox"/> Too Demanding
<input type="checkbox"/> Divorced	<input type="checkbox"/> Professional School	<input type="checkbox"/> Normal	<input type="checkbox"/> Boring
<input type="checkbox"/> Widowed	<input type="checkbox"/> Other:	<input type="checkbox"/> Don't Recall	<input type="checkbox"/> Satisfactory

Living arrangement:

Alone family roommate significant other

Children (list sex/ages): _____

Major stresses in last 6 months Money Job Marriage Home Life Children

Other stressors _____

Pertinent travel history :(out of USA or epidemic areas)

Lifestyle / Self-Care

Do you smoke cigarettes?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how many? #_____ yrs. _____ packs per day
Did you ever smoke?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when did you quit? _____
Do you drink alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much? Type_____ & _____ drinks per week
Do you drink caffeinated beverages?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, which? _____
Do you use recreational drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, which? _____
Do you manage stress well?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not Sure	<input type="checkbox"/> Need help
Do you exercise regularly?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Do you enjoy your job?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Do you allow time to unwind and relax?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Do you sleep soundly?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Are you satisfied with your sex life?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Are you satisfied with your social life?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Are you satisfied with your spiritual life?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Is your diet healthy enough?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	<input type="checkbox"/> NEED HELP

Typical breakfast _____

Typical lunch _____

Typical dinner _____

Typical snacks _____

Devices You Use:

___ Eyeglasses	___ Contact Lens	___ Hearing Aid	___ Dentures
___ Brace (Neck, Back)	___ Pacemaker	___ Wheel Chair	___ Artificial Limbs

Check any symptoms that currently apply to you:

Constitutional

- poor appetite
- fevers
- chills
- food craving
- weight loss
- weight gain
- fatigue

Eyes

- eye pain
- blurred vision
- poor vision__day
- poor vision__night
- wear corrective lenses
- near__farsighted
- other

Ears,Nose,Mouth,Throat

- ringing ears
- nosebleed
- postnasal drip
- sinus problems
- trouble with taste/smell
- poor hearing
- earaches

Immune System

- too many infections
- allergies to food
- allergies to environment
- other concerns

Blood System

- lymph gland swelling
- anemia
- easy bruising

Ears, Nose, Mouth, Throat Cont

- headaches
- jaw clicks
- teeth problems
- grinding teeth
- trouble chewing
- facial pain
- sore throat
- mouth sores
- bad breath

Heart & Circulation

- chest pain
- lightheadedness
- palpitations
- cold hands/feet
- varicose veins
- fainting
- swelling feet
- blood clots

Breathing & Lungs

- shortness of breath
- wheezing or asthma
- repeated colds/flu
- cough dry/irritating

Sexual Organs

- sores on genitals
- lumps or swelling
- erection problems
- repeated infections
- poor sexual response
- pain with sex
- infertility

Muscles, Bones & Joints

- neck pain
- back pain
- muscle pain
- painful joints: R__L__
- shoulder__elbow
- hip__knee__ankle
- wrist__fingers
- muscle cramps
- joint swelling
- muscle weakness

Skin, Hair, Breast

- breast lumps or pain
- breast leaks fluid
- rashes
- dry skin, eczema
- itching, hives
- hair loss

Nerves, Movement, Brain

- seizures
- nerve pain
- poor balance
- poor coordination
- tremors or shaking

Women

- pelvic pain
- vaginal discharge
- painful periods
- itching or soreness
- premenstrual syndrome
- hot flashes

Digestion & Intestine

- indigestion
- belching
- difficulty swallowing
- heartburn
- nausea
- liver trouble
- vomiting
- blood in stool
- diarrhea
- cramping bowels
- gassy gut
- constipation
- abdominal pain
- rectal pain/itching
- hemorrhoids/piles

Urine, Kidney, Bladder

- painful urination
- wake up to urinate
- kidney stones
- loss of control
- frequent urination
- sudden urge
- blood/pus urine

Reproductive

- age period started
- # of pregnancies
- # abortions
- # live births
- # miscarriages
- past infertility
- children currently living
- age menopause __

If Not Noted It Is Either Non-Contributory, And / Or Non-Pertinent

Health screening History**Patient Name:****List the date of your most recent test or exam:**

Mammogram _____ Pap Smear _____ Self Breast Exam _____ Breast Exam by Doctor _____
 Blood test for Cholesterol _____ Blood Sugar _____ Other Blood tests _____
 Immunizations: Polio _____ Tetanus _____ Hepatitis _____ Pneumonia _____ Flu Shot _____
 Test for Blood in stool _____ Rectal Exam _____ Feeling the Prostate _____ Scope Lower Bowel _____
 Self Exam Testicle _____ Testicle Exam by Professional _____

Anatomy\Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	Pet Scan	EMG
Back							
Brain							
Chest							
Colon							
Extremities (Arm/ Leg)							
Gallbladder							
Kidney							
Neck							
Pelvis							
Stomach							
Other							

List any additional information that would be beneficial to Dr. Gonzalez in managing your medical care including any alternative treatment who have received:

Please describe your condition from when you first began to experience symptoms up to this date. Elaborate in detail how it has affected you in terms of motion, sensitivity, coordination, independence, pain, fatigue, emotion, self-esteem, way of life, and approach to your future:
