

**OPTIMAL HEALTH CENTER  
74361 HIGHWAY 111, SUITE 3  
PALM DESERT, CA 92260  
(760) 568-2598**

**NEW PATIENT INTAKE FORM**

**PATIENT INFORMATION / PROFILE**

|             |  |  |
|-------------|--|--|
| Name:       | Date of Birth:   | Gender: M F Other  |
| Address:    | <input type="checkbox"/> Single <input type="checkbox"/> Married | <input type="checkbox"/> Divorced <input type="checkbox"/> Other |
| (zip)       | Employer / School:   |  |
| Occupation: |  |  |

**Contact Information**

|  |       |             |       |
|--|-------|-------------|-------|
| Phone Numbers:   | Work: | Home:       | Cell: |
| <b>Which number may be used to leave a private message with confidential health information?</b> |       |             |       |
| Confidential E-mail Address:   |       |             |       |
| (To Be Used For Dr/Patient Communication)  |       |             |       |
| Emergency Contact :  |       | home phone: |       |
| Relationship to patient:   |       | work phone: |       |

**REFERRALS AND ADJUNCTIVE CARE**

|  |
|--|
| Are you currently under medical care? <input type="checkbox"/> No <input type="checkbox"/> Yes For:  |
| Please list other health care professionals from whom you receive care (name, specialty, contact # if possible)  |
|  |
| How did you find Dr. Sinsheimer?<br><input type="checkbox"/> Physician Referral: <input type="checkbox"/> Patient Referral: <input type="checkbox"/> Internet: <input type="checkbox"/> Other: |
| Referring Physician or Patient Name:   |
|  |

**HEALTH CONCERNS (please list in order of importance to you)**

|  |    |
|--|----|
| 1.   | 4. |
| 2.   | 5. |
| 3.   | 6. |
| Are you currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes Months? |    |
|  |    |
| What goals do you have from your visit today and overall?                                    |    |
|  |    |

|  |
|--|
| What expectations do you have of your physician? |
|  |
|  |

**MEDICATIONS AND SUPPLEMENTS**

|  |    |
|--|----|
| <b>Medications &amp; dose:</b>             |    |
| 1.   | 4. |
| 2.   | 5. |
| 3.   | 6. |
|  |    |
| <b>Supplements (vitamins, herbs, etc):</b> |    |
| 1.   | 4. |
| 2.   | 5. |
| 3.   | 6. |
|  |    |

**HEALTH HISTORY / REVIEW OF SYSTEMS**

|                                       |                                 |   |                                      |  |
|---------------------------------------|---------------------------------|---|--------------------------------------|--|
| <b>Allergies or Reactions to:</b>     | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin / antibiotics | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Local anesthetics |
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Nuts   | <input type="checkbox"/> Scents                   | <input type="checkbox"/> Other:      |  |
| <b>Serious illnesses:</b>             |                                 |   |                                      |  |
|                                       |                                 |   |                                      |  |
| <b>Accidents:</b>                     |                                 |   |                                      |  |
|                                       |                                 |   |                                      |  |
| <b>Hospitalizations / operations:</b> |                                 |   |                                      |  |
|                                       |                                 |   |                                      |  |

**Family History**

|                                   |                                 |   |                          |      |
|-----------------------------------|---------------------------------|---|--------------------------|------|
| Mother:                           | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased           | Cause                    | Age: |
| Father:                           | <input type="checkbox"/> Living | <input type="checkbox"/> Deceased           | Cause                    | Age: |
| Siblings:                         | Number living:                  | Number deceased:                            | Causes / Ages:           |      |
| Children:                         | Number living:                  | Number deceased:                            | Causes / Ages:           |      |
| <b>Has any family member had:</b> | <b>Yes</b>                      | <b>Which Relative(s) &amp; Age of Onset</b> | <b>Physician's Notes</b> |      |
| Diabetes                          | <input type="checkbox"/>        |   |                          |      |
| Stroke                            | <input type="checkbox"/>        |   |                          |      |
| Heart Disease                     | <input type="checkbox"/>        |   |                          |      |
| Heart Attack                      | <input type="checkbox"/>        |   |                          |      |
| High Blood Pressure               | <input type="checkbox"/>        |   |                          |      |
| High Cholesterol                  | <input type="checkbox"/>        |   |                          |      |
| Kidney Disease                    | <input type="checkbox"/>        |   |                          |      |
| Osteoporosis                      | <input type="checkbox"/>        |   |                          |      |
| Hepatitis                         | <input type="checkbox"/>        |   |                          |      |
| Thyroid problems                  | <input type="checkbox"/>        |   |                          |      |
| Breast Cancer                     | <input type="checkbox"/>        |   |                          |      |
| Colon Cancer                      | <input type="checkbox"/>        |   |                          |      |
| Ovarian Cancer                    | <input type="checkbox"/>        |   |                          |      |