

## Beth Netter, M.D.

### Acupuncture

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#### Medical History Intake Form

**Please print and fill out this form and bring it with you to your first appointment**

#### General Information:

Name:

Referred By:

Date:

Email address:

Home address:

Phone numbers: Home: (    ) \_\_\_\_\_ Work: (    ) \_\_\_\_\_ Cell (    ) \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ F/M \_\_\_\_\_ Height: \_\_\_\_\_ Weight \_\_\_\_\_

Occupation:

1. Please list your primary health challenges (physical, mental, emotional) that you would like to focus on:

2. Were there any problems during your birth (or traumas/difficulties experienced by your mother while she was pregnant with you)?

3. Childhood Illnesses, surgeries or accidents (For listing of surgeries please include all investigative surgery and invasive diagnostic procedures such as a laparoscopy or peritoneoscopy):

Age:

Age:

4. Adulthood: Surgeries or accidents (illnesses will be covered below):

Age:

Age:

Age:

Age:

5. Your medical Issues. The following is a thorough list of symptoms and medical issues.

**Please check all that have applied to you within the past 3 years.**

**Please circle any that apply this week in particular.**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abdominal pain         | <input type="checkbox"/> Decreased sweating      | <input type="checkbox"/> Hormone replacement     |
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Dementia                | <input type="checkbox"/> Hot flashes             |
| <input type="checkbox"/> Addiction              | <input type="checkbox"/> Depression              | <input type="checkbox"/> Hunger-extreme          |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Diabetes Type I         | <input type="checkbox"/> Impotence               |
| <input type="checkbox"/> Anorexia/bulimia       | <input type="checkbox"/> Diabetes Type II        | <input type="checkbox"/> Incontinence            |
| <input type="checkbox"/> Anxiety/Panic          | <input type="checkbox"/> Diarrhea/loose stools   | <input type="checkbox"/> Infertility             |
| <input type="checkbox"/> Arrhythmia             | <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Insomnia                |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Dry skin or hair        | <input type="checkbox"/> Irregular periods       |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Eating disorder         | <input type="checkbox"/> Irritability            |
| <input type="checkbox"/> Attention Disorder     | <input type="checkbox"/> Eczema                  | <input type="checkbox"/> Irritable bowel         |
| <input type="checkbox"/> Autoimmune Disease     | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Joint aches             |
| <input type="checkbox"/> Back pain/tension      | <input type="checkbox"/> Endometriosis           | <input type="checkbox"/> Kidney disease          |
| <input type="checkbox"/> Belching               | <input type="checkbox"/> Energy drops            | <input type="checkbox"/> Leg pain                |
| <input type="checkbox"/> Bladder problems       | <input type="checkbox"/> Excess gas              | <input type="checkbox"/> Liver disease/hepatitis |
| <input type="checkbox"/> Bloating               | <input type="checkbox"/> Expanding waist         | <input type="checkbox"/> Low blood pressure      |
| <input type="checkbox"/> Bone loss              | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Low energy              |
| <input type="checkbox"/> Brain fog              | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Low libido              |
| <input type="checkbox"/> Break-thru bleeding    | <input type="checkbox"/> Fibrocystic breasts     | <input type="checkbox"/> Lung issues             |
| <input type="checkbox"/> Breast cancer          | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Memory problems         |
| <input type="checkbox"/> Breast tenderness      | <input type="checkbox"/> Fluid retention         | <input type="checkbox"/> Menopause               |
| <input type="checkbox"/> Brittle/breaking nails | <input type="checkbox"/> Forgetfulness           | <input type="checkbox"/> Metabolic syndrome      |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Gait imbalance          | <input type="checkbox"/> Migraines               |
| <input type="checkbox"/> Celiac disease         | <input type="checkbox"/> Gallbladder issues      | <input type="checkbox"/> Missed periods          |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Gastric reflux          | <input type="checkbox"/> Mood swings             |
| <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Gastrointestinal issues | <input type="checkbox"/> Multiple sclerosis      |
| <input type="checkbox"/> Chronic cough          | <input type="checkbox"/> Gluten intolerance      | <input type="checkbox"/> Muscle pain             |
| <input type="checkbox"/> Chronic lung disease   | <input type="checkbox"/> Hair loss               | <input type="checkbox"/> Muscle stiffness        |
| <input type="checkbox"/> Chronic pain           | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Muscle weakness         |
| <input type="checkbox"/> Cold hands/feet        | <input type="checkbox"/> Head injury             | <input type="checkbox"/> Nausea/vomiting         |
| <input type="checkbox"/> Cold intolerance       | <input type="checkbox"/> Hearing loss            | <input type="checkbox"/> Neck pain/tension       |
| <input type="checkbox"/> Concentration problem  | <input type="checkbox"/> Heart disease           | <input type="checkbox"/> Nervous energy          |
| <input type="checkbox"/> Confusion              | <input type="checkbox"/> Heart attack (MI)       | <input type="checkbox"/> Neuropathy              |
| <input type="checkbox"/> Congestive Heart Dis.  | <input type="checkbox"/> Heat intolerance        | <input type="checkbox"/> Night sweats            |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Heart palpitations      | <input type="checkbox"/> Nipple discharge        |
| <input type="checkbox"/> Cramps with period     | <input type="checkbox"/> Heavy periods           | <input type="checkbox"/> Nonrestorative sleep    |
| <input type="checkbox"/> Cravings               | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Obesity                 |
| <input type="checkbox"/> Crohn's Disease        | <input type="checkbox"/> High cholesterol        | <input type="checkbox"/> Oily skin               |
| <input type="checkbox"/> Cysts                  | <input type="checkbox"/> High triglycerides      | <input type="checkbox"/> Ovarian cysts/PCO       |
| <input type="checkbox"/> Decreased appetite     | <input type="checkbox"/> Hoarseness              | <input type="checkbox"/> Pain (acute)            |

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pain (chronic)        | <input type="checkbox"/> Scanty period flow      | <input type="checkbox"/> Thyroid disease    |
| <input type="checkbox"/> Painful intercourse   | <input type="checkbox"/> Seizures                | <input type="checkbox"/> Tremors            |
| <input type="checkbox"/> Panic attacks         | <input type="checkbox"/> Sensitivities-chemicals | <input type="checkbox"/> Ulcer              |
| <input type="checkbox"/> Pelvic pain           | <input type="checkbox"/> Sensitivities-foods     | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Phobias               | <input type="checkbox"/> Shakiness               | <input type="checkbox"/> Unusual sensations |
| <input type="checkbox"/> Pituitary issues      | <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Urination problems |
| <input type="checkbox"/> PMS                   | <input type="checkbox"/> Sleep apnea             | <input type="checkbox"/> Uterine fibroids   |
| <input type="checkbox"/> Poor appetite         | <input type="checkbox"/> Slow pulse              | <input type="checkbox"/> Vaginal discharge  |
| <input type="checkbox"/> Poor concentration    | <input type="checkbox"/> Slowed reflexes         | <input type="checkbox"/> Vaginal dryness    |
| <input type="checkbox"/> Poor sleep            | <input type="checkbox"/> SLE/Lupus               | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Prolonged bleeding    | <input type="checkbox"/> Snoring                 | <input type="checkbox"/> Vaginal pain       |
| <input type="checkbox"/> Prostate problems     | <input type="checkbox"/> Sexually T.D.           | <input type="checkbox"/> Wake too early     |
| <input type="checkbox"/> Psoriasis             | <input type="checkbox"/> Stiffness, esp. a.m.    | <input type="checkbox"/> Weight-not losing  |
| <input type="checkbox"/> Puffy eyes/face       | <input type="checkbox"/> Stressed easily         | <input type="checkbox"/> Weight gain        |
| <input type="checkbox"/> Radiation therapy     | <input type="checkbox"/> Tender spots            | <input type="checkbox"/> Weight loss        |
| <input type="checkbox"/> Rashes                | <input type="checkbox"/> Thick tongue            | <input type="checkbox"/> Wheezing           |
| <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Thinning skin           |   |
| <input type="checkbox"/> Restless sleep        | <input type="checkbox"/> Tinnitus                |   |

6. If you checked anything from the previous list, you are invited to describe it in more detail now. Please add any other important medical issues not included here.

Please describe what has helped and what has not helped (medications, procedures, allopathic and/or holistic therapies) and what you are currently applying to support any of these issues (you may add others on the back of these sheets).

(1) Symptom or Health Challenge:

Description:

(2) Symptom or Health Challenge:

Description:

(3) Symptom or Health Challenge:

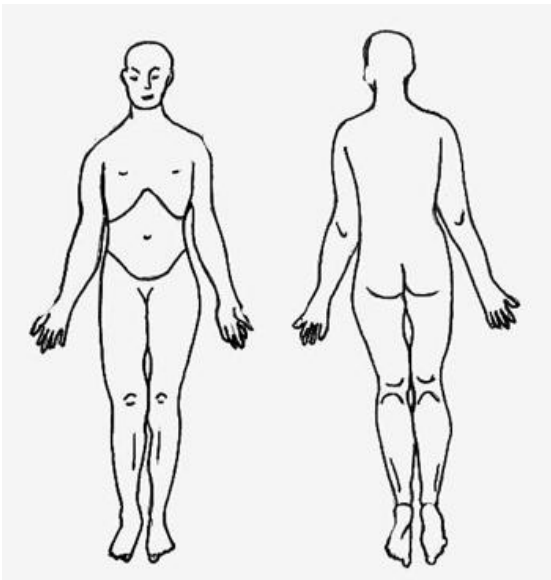
Description:

6. Please list any notable laboratory values (cholesterol, blood sugar, thyroid tests). (You may either fax to Dr. Netter's office at: 518-641-6939 or bring with you any significant laboratory results from the past years.):

7. Typical blood pressure (if you know this):

8. If you experience pain:

- Please describe the pain (including location, characteristics, is it intermittent or continuous) and mark its location on the body diagram below:



- Please rate the level of pain experienced: 0 (no pain)-10 (unbearable):
- What have you tried but has not helped alleviate the pain in the past?
- What has helped alleviate the pain in the past?

9. Please note all major illnesses in your *immediate family* like diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders, cancer, etc. Please note the disease and the relative involved (i.e., father, mother, brother, sister, child, aunt, uncle, grandparent):

10. Please list and describe any scars including any notable vaccination scars. Note location of all operation or injury scars (even minor ones):

11. Over the counter and prescription medications (Please list the medication and what it is used for):

12. Vitamins, herbal treatments, supplements:

13. Alcohol consumption:

<u>Type of Alcohol</u>	<u>Amount (#) Consumed/Week</u>
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Beer

Wine

Liquor

14. Have you ever smoked cigarettes?

Yes

No

If yes and you still currently smoke:

How many packs per day do you smoke?:

For how many years have you smoked?:

Have you ever tried to quit?:

Yes

No

15. Recreational drug use:

16. # hours of television watched each day:

17. # hours spent on the computer and/or Blackberry/I-phone each day:

18. # hours reading each day:

19. Exercise

- Do you exercise?  
 Yes  No
- What do you do for exercise?
- How often do you exercise per week?

20. Other health practices (circle or described): Meditation, breathing, yoga.

21. Relationships (Please answer all that are applicable to you).

- Quality of relationship with partner/spouse/mate. Please write name and date of birth of partner.(0=very poor to 10=excellent):
- Quality of relationship with children. Please write name and date of birth of child. (0=very poor to 10=excellent):
- Quality of relationship with parents. Please answer even if parent not still living. If not still living please note name and date of passing of parent. (0=very poor to 10=excellent):
- Quality of relationship with coworkers. (0=very poor to 10=excellent):
- Quality of relationship with friends (in general)(0=very poor to 10=excellent):

22. Stress

- How do you feel at the end of a typical day?
- What helps you deal with this stress?

23. Sleep

- Do you awake rested?  
 Yes  No
- Do you have trouble falling asleep or wake up during the night?  
 Yes  No

