Dr. Sarah Elizabeth Anderson Wylie, ND
Rose Pavilion @ 25 Mountain View St, Suite E, Bristol, VT 05443
Burlington Natural Health Center @ 13 Kilburn St, Burlington, VT 05401
802-453-2777

Patient name _____ Date of First Visit _____

Address _____

Telephone # (home)_____ (cell)_____

Can I leave a message with detailed information about your health? _____

Email:_____

Age _____ Date of Birth _____ Gender_____

Ethnicity_____ Race _____ Preferred Language _____

Marital Status_____ I live with_____

Occupation _____ Hours per week _____ Retired _____

Emergency Contact _____Relationship _____ Phone _____

Who is your Primary Care Provider?_____

When and where did you last receive health care?_____

What was the reason?_____

Insurance Company_____ Subscriber ID # _____Group #_____

Primary Subscriber Name_____ Date of Birth _____

How did you hear about Red Blossom Medicine? _____

What are your most important health problems? List as many as you can in order of importance.

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

General

Weight_____ lb.. Height_____

What is the most you have ever weighed, and when?_____

Have you received the standard schedule of immunizations for your generation? _____

If not, how was it different?_____

Have you received any extra immunizations due to travel or military service? _____

If so, which vaccines?_____

Any significant childhood illnesses? _____

Any accidents to tailbone or head?_____

Current Medications	please list:				
Laxatives		Pain relievers		Antacids	
Cortisone		Sleeping Pills		Thyroid medications	

Nutritional Supplements/Botanicals:	

Allergies Are you hypersensitive or intolerant to:

Any drugs?_____

Any foods?_____

Any environmentals?_____

Hospitalization and Surgery

What hospitalizations or surgeries have you had? Please list the date.

_____

_____

X-rays and Special Studies

X-rays, CAT scans, MRI, sonograms, Mammograms, EKGs, Bone Density, etc.

_____

_____

_____

Family History

	Mother	Father	Brothers	Sisters	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Age (if living)								
Health (G=good, P=poor)								
Age at death (if deceased)								
Cause of Death								
Check (√)those Applicable								
Cancer - what type?								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Epilepsy								
Mental Illness								
Allergies/Hay-fever/Hives								
Asthma								
Eczema								
Anemia								
Kidney Disease								
Liver Disease								
Tuberculosis								
Reproductive Organ Illness								
other illnesses not listed								
extended family illnesses								

REVIEW OF SYSTEMS:

Please differentiate symptoms: **(Y)es for present and (N) for Never or (P) for Past and Significant**. Write in any symptoms not listed, and leave blank if you don't know what the condition is.

Immune					
Food Allergies	Y N P	recurrent infections	Y N P	autoimmune disease, please list	Y N P
Blood					
Easy bruising	Y N P	Varicose veins	Y N P	Cold hands/feet	Y N P
leg pain	Y N P	Anemia	Y N P	swelling in ankles	Y N P
blood clotting problems	Y N P	cracked heels	Y N P	Family history of stroke	Y N P
Skin					
Rashes	Y N P	Acne, pimples, boils	Y N P	Hair loss	Y N P
Itching	Y N P	Color Change	Y N P	Night sweats	Y N P
Head					
Headaches	Y N P	Migraines	Y N P	Head Injury	Y N P
Eyes					
Impaired vision	Y N P	infection	Y N P	floaters	Y N P
Glasses or contacts	Y N P	dry eyes	Y N P	Eye pain/strain	Y N P
Ears					
Impaired hearing	Y N P	Ringing	Y N P	pain	Y N P
sensitive to sound	Y N P	Excessive Wax	Y N P		
Nose & Sinuses					
Frequent colds	Y N P	Nose bleeds	Y N P	Stuffiness	Y N P
Allergies	Y N P	recurrent Sinus pain	Y N P	Loss of smell	Y N P
Mouth & Throat					
Frequent sore throat	Y N P	cavities	Y N P	Teeth grinding	Y N P
Sore lips	Y N P	Gum problems	Y N P	TMJ	Y N P
Neck					
Pain	Y N P	Swollen glands	Y N P	Stiffness	Y N P
Respiratory					
Cough	Y N P	Tuberculosis	Y N P	Spitting up blood	Y N P
difficulty breathing	Y N P	Asthma	Y N P	Infections	Y N P
Cardiovascular					
Heart disease	Y N P	Chest pain	Y N P	Murmurs	Y N P
High blood pressure	Y N P	Low blood pressure	Y N P	Fainting	Y N P
Palpitations/fluttering	Y N P			Blood clots	Y N P
Gastrointestinal					
Gall bladder disease	Y N P	Rectal Incontinence	Y N P	Liver disease	Y N P
Trouble swallowing	Y N P	Heartburn	Y N P	Change in thirst	Y N P
Change in appetite	Y N P	Nausea	Y N P	Vomiting	Y N P
Vomiting blood	Y N P	Blood in stool	Y N P	Pain or cramps	Y N P
Belching or passing gas	Y N P	Constipation	Y N P	Diarrhea	Y N P
Ulcers	Y N P	Fissures	Y N P	Hemorrhoids	Y N P
Bowel movements	how often?		Loose/formed?	Is this a change?	
Urinary					
Pain on urination	Y N P	Increased frequency	Y N P	Incontinence	Y N P
Frequency at night	Y N P	Frequent infections	Y N P	Kidney stones	Y N P

Musculoskeletal					
MVA - car crashes	Y N P	joint stiffness	Y N P	Injury to tailbone	Y N P
Joint pain	Y N P	Broken bones	Y N P	Sacrum Injury	Y N P
Muscle spasm	Y N P	Low back pain	Y N P	Upper Back Pain	Y N P
Arthritis	Y N P	Weakness	Y N P	Sciatica	Y N P
Neurologic					
Seizures	Y N P	Paralysis	Y N P	Muscle weakness	Y N P
Numbness	Y N P	Tingling	Y N P	Easily overwhelmed	Y N P
Vertigo or dizziness	Y N P	Loss of balance	Y N P	Amnesia	Y N P
Endocrine					
Hypothyroid	Y N P	Hyperthyroid	Y N P	Cold intolerance	Y N P
heat intolerance	Y N P	Excessive thirst	Y N P	Hypoglycemia	Y N P
Diabetes	Y N P	weight loss	Y N P	weight gain	Y N P
insomnia	Y N P	Fatigue	Y N P	Seasonal Depression	Y N P
Mental & Emotional					
Treated for emotional problems	Y N P	Considered/ Attempted Suicide	Y N P	Anxiety	Y N P
Mood swings	Y N P	Depression	Y N P	Memory problems	Y N P
Poor concentration	Y N P	Tension	Y N P	History of Abuse	Y N P
Trauma	Y N P	PTSD	Y N P	eating disorder	Y N P
STIs					
Genital warts	Y N P	HPV	Y N P	Chlamydia	Y N P
Herpes	Y N P	Syphilis	Y N P	Gonorrhea	Y N P
Male Reproduction					
Testicular masses	Y N P	Testicular pain	Y N P	Hernias	Y N P
Prostate disease	Y N P	Past Infections	Y N P	Sores	Y N P
Premature ejaculation	Y N P	Impotence	Y N P	Birth Control Typer?	Y N P
Female Reproductive					
Age of first menses		Are cycles regular?		How many days between menses?	
How many days of bleeding?		Clotting	Y N P	Dark, Thick Blood	Y N P
Painful Periods	Y N P	Spotting before menses	Y N P	Bleeding between cycles	Y N P
Heavy	Y N P	Light flow	Y N P	Dizziness with menses	Y N P
PMS symptoms?		Cervical Fluid with ovulation?		Other vaginal discharge?	
Recurrent Ovarian Pain	Y N P	Ovulation Pain	Y N P	Ovulation Bleeding	Y N P
Failure to Ovulate	Y N P	Ovarian cysts	Y N P	Ovarian Cancer	Y N P
Pain during intercourse	Y N P	Dry Vagina	Y N P	Vaginitis	Y N P
Endometriosis	Y N P	Fibroids	Y N P	Abnormal PAP/date	
Family history of ovarian cancer	Y N P	“Tipped Uterus”	Y N P		
Contraception		What type?			
Number of pregnancies		# of Live births		# of miscarriages	
Number of abortions		Birthing Trauma?		Pre-term infants	
Difficulty Conceiving		Fertility Charting		Sexual orientation?	
Breast pain	Y N P	Breast lumps	Y N P	Nipple discharge	Y N P

Breast feeding	Y N P	Breast self-exams?			
Menopause		Hot Flashes	Y N P	Menstrual Flooding	Y N P
Sexuality		Libido —>	good moderate poor	Orgasm —>	never sometimes usually

Past & Present Use of Contraception: List length of time using method

Pill	Shot	Patch	Ring
Diaphragm	Cap	Condoms	FAM
IUD - copper	IUD - Hormonal	Abstinence	

If you are under treatment for fertility, please describe your fertility treatment to date:
_____
_____

_Trauma

Do you have a history of rape or trauma? _____
If so, what ages did this occur?_____
How have you healed from this?_____

Spiritual:

How does your condition affect you? _____
_____
What do you think is happening? _____
_____
Why? _____
Do you have a spiritual practice?_____
Is there any information about your health you would like to add? _____
_____

CONSENT TO TREATMENT

I, the undersigned, understand that methods of evaluation used in this practice may include, but are not limited to, physical exams (vitals, musculoskeletal, EENT, heart and lung, orthopedic, dermatologic, and neurological assessments) and diagnostic procedures (including venipuncture, diagnostic imaging, and laboratory evaluation of blood, urine, stool, and saliva).

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to naturopathic medicine, naturopathic physical medicine, botanical medicine, homeopathy, massage, hydrotherapy, nutritional supplements, pharmaceutical prescriptions, sauna therapy, and lifestyle and nutritional counseling.

I understand that naturopathic medicine, naturopathic physical medicine, herbal therapy, homeopathy, massage, hydrotherapy, nutritional supplements, sauna therapy, pharmaceutical prescriptions, and nutritional counseling are safe methods of treatment. Potential risks are uncommon but may include nausea, headache, stomachache, vomiting, diarrhea, rashes, hives, or dizziness. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify Dr Sarah Wylie should I become pregnant or if I am in the process of trying to get pregnant so that she can avoid treatments, medications, supplements, and herbs that could induce miscarriage. Otherwise, Naturopathic medical treatment can be very beneficial in the pregnancy and birthing process. I understand that herbal and nutritional supplements recommended to me by Dr Sarah Wylie are safe in the recommended doses. Large doses of herbs or supplements taken without my practitioner's recommendation may be toxic, and some herbs and supplements are inappropriate during pregnancy. Some possible side effects of herbs or supplements are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and dizziness. I understand that if I experience any adverse effects from herbs, supplements, or medications prescribed by Dr Sarah Wylie that I must stop taking these herbs, supplements, or medications and notify Dr Sarah Wylie as soon as I experience any discomfort or adverse reactions.

I understand that Dr Sarah Wylie may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with Dr Sarah Wylie before signing if I so choose. However, I do not expect Dr Wylie to be able to anticipate and explain all possible risks and complications of treatment. I rely on Dr Sarah Wylie to exercise her judgment in my best interest during the course of treatment, based upon the facts then known.

_____ Patient Signature Date