Desert Oasis CLINIC
"Where The Healing Begins."
John A. Thompson, D.O. - *Medical Director*

Patient Information

Name:_____ Social Security No.:_____
(Last First MI)

Address:_____City:_____State:_____Zip: _____

Sex: ☐ M ☐ F Age:_____Date of Birth:_____Marital Status:_____

Employer:_____Occupation:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Best daytime phone (*between 8:00 a.m. and 5:00 p.m.)* ☐ Home ☐ Work ☐ Cell
Best evening phone (*after 5:00 p.m.)* ☐ Home ☐ Work ☐ Cell

E-mail:_____

Emergency Contact:_____Relationship:_____Phone:_____

Primary Care Physician:_____

If patient is a minor: Parent/Guardian:_____
(Last First)

How were you referred to us? _____

Patient or Guardian Signature:_____Date:_____

DESERT OASIS CLINIC
PATIENT HEALTH HISTORY

Name:_____ **D.O. B:**_____

HEALTH PRIORITIES:

What symptoms, problems or health-related goals would you like to have addressed? Please list them in order of importance to you.

1._____

2._____

3._____

4._____

ALLERGIES:

To medications, foods, or other substances:

_____

_____

_____

_____

_____

Choose three words to describe how you usually feel physically:

1._____ 2._____ 3. _____

Choose three words to describe how you usually feel emotionally:

1._____ 2._____ 3._____

Do you currently smoke cigarettes?

☐ YES, I do now. How much? _____

☐ NO, I did but quit. How long ago?_____

☐ NO, I have never smoked cigarettes.

Do you currently smoke cigars or a pipe?

☐ YES, I do now. How much? _____

☐ NO, I did but quit. How long ago?_____

☐ NO, I have never smoked cigars or a pipe.

Current Medications		
Name of Medication	**For What Reason?**	**For How Long Have You Took This Medication?**

Name:_____

Please CIRCLE any of the following that you now have or have had in the past:

High Cholesterol	Hepatitis	COVID-19	Carpal Tunnel Syndrome
High Blood Pressure	Fatty Liver or Cirrhosis	Asthma	Osteopenia or Osteoporosis
Coronary Artery Disease	Gallbladder Problems	Pneumonia	Osteoarthritis
Atherosclerosis	Lupus	Tuberculosis	Rheumatoid Arthritis
Peripheral Artery Disease	Multiple Sclerosis	Chronic Fatigue Syndrome	Bulging/Herniated Disc
Congestive Heart Failure	Parkinson's Disease	Fibromyalgia	Degenerative Disc Disease
COVID-19	Kidney Disease	Epstein Barr Virus	Spinal Stenosis
Stroke or TIA	Kidney Stones	Cancer	Sciatica
Aneurysm	Hypothyroidism	Herpes Virus	Scoliosis
Bleeding/Clotting Disorder	Hyperthyroidism	Shingles	Torn Ligament or Tendon
Stomach/Duodenal Ulcer	Sleep Disorder	Lyme Disease	Joint Replacement
Colitis or Spastic Colon	Migraine Headaches	HIV Positive	Whiplash
Gluten Sensitivity or Celiac	Neuropathy or Neuralgia	High PSA	Clinical Depression
Crohn's Disease	Epilepsy or Seizures	Enlarged Prostate	Manic Depressive Disorder
Diverticulitis	Cataracts	Other Prostrate Trouble	Schizophrenia
Irritable Bowel Syndrome	Glaucoma	Uterine Fibroids	Obsessive/Compulsive Disorder
Colon Polyps	Macular Degeneration	Ovarian Cyst	Attention Deficit Disorder
Pancreatitis	Hearing Impairment	Abnormal Pap Smear	Alcoholism
Hypoglycemia	Emphysema	Endometriosis	Drug Addiction
Type I Diabetes	Bronchitis	Fibrocystic Breasts	Nicotine Addiction
Type II Diabetes	Seasonal Allergies	Breast Tumor or Cyst	
Pre-Diabetes	Food Allergies		

Other conditions/diagnoses not listed above: _____

_____

_____

List any previous surgeries and the year performed:

_____

_____

If you have ever had cancer, which organ(s) were involved, how long ago were you diagnosed, and what type of treatment did you receive.

_____

_____

How frequently do you experience each of the following?

	Never or Rarely	Occasionally	Often
Upset stomach / indigestion			
Belching or intestinal gas			
Bloating or distention			
Acid stomach or gastric reflux			
Constipation or hard stool			
Loose stool or diarrhea			
Mucus in stool			
Blood in stool or rectal bleeding			
Anal itching			
Loss of appetite			
Cough			
Wheezing			
Shortness of breath			
Snoring or sleep apnea			
Difficulty sleeping			
Pain that interferes with sleep			
Tinnitus / ringing in ear			
Sinus problems			
Nasal congestion / stuffy nose			
Back or neck pain			
Pain that radiates down the leg			
Painful, swollen or tender joint (s)			
Muscle pain, aches, stiffness			
Joint or muscle weakness			
Irregular heartbeat or palpitations			
Chest pressure, pain or angina			
Rapid or racing heartbeat			
Shortness of breath on exertion			
Pain in calf on exertion			
Easy bruising or bleeding			
Water retention in legs, ankles, feet			
Frequent urination			
Excessive thirst			
Blurred vision			

	Never or Rarely	Occasionally	Often
Headaches			
Low energy; fatigue; feel tired			
Infections, colds, or flu			
General weakness			
Low blood pressure			
Low body temperature or feel cold			
Get lightheaded upon standing up			
Hypoglycemia (low blood sugar)			
Alcohol intolerance or severe hangovers			
Craving for sweets or starches			
Craving for salty foods			
Excessive hunger			
Have a difficult time handling stress			
Feel anxious, nervous, frustrated, irritable			
“Brain fog” or moments of confusion			
Poor memory			
Feel depressed, moody, or sad			
Feel apprehensive, fearful, worried			
Have difficulty building muscle			
Low libido; little interest in sex			
Difficulty recovering from exercise			
Feel unrested after sleep			
Palpitations (heart fluttering)			
Tendency towards inflammation			
Scanty perspiration			
Dizziness or vertigo			
Allergies or hay fever			
Need caffeine or other stimulants			
Unexplained hair loss			
Dry or thin skin			
Difficulty losing weight			
Dry, brittle hair and or nails			
Unexplained hair loss			
Numbness or tingling in arm, hand, foot			