True Health Medical Center

Adult New Patient Screening Form

All fields must be completed to be considered for an appointment.

1. ***Patient's Name**: _____ **DOB:**_____ **Sex**: **M F***

   ***Phone:** _____ **Email:** _____*

   ***State:** _____ **Country:** _____*

2. ***Chief complaint/symptom or reason for seeking an appointment (please be specific):***

3. ***Do you have any medical diagnosis?***

4. ***Do you have any other medical issues, major surgeries, or hospitalizations? If so, please describe:***

5. ***THMC does not provide primary care physician services. Do you have a primary care physician? Y N***

6. ***What medications and supplements do you currently take?***

7. ***Do you speak English? Y N If not, will you have an interpreter available for all consultations?***