Hopkins DERMATOLOGY

Functional Medicine Workup Intake Form

General Information

Name		Date of Birth	
Email			
Address		City	
State		Zip Code	
Preferred Phone Number		☐ Mobile	☐ Home

How did you hear about this program?

☐ Current Hopkins Dermatology Patient

☐ Hopkins Dermatology Website

☐ Social Media

☐ Referral from Friend or Family

☐ Other _____

Medical History

Past Medical History

_____

_____

_____

_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long-Term Partner ☐ Widow/er

Current Occupation	
Previous Occupations	

Medications & Supplements

Current Prescription Medications

Medication Allergies: ☐ No ☐ Yes _____

Current Supplements

Do you use tobacco?	☐ No ☐ Yes
Do you drink alcohol?	☐ No ☐ Yes

If yes, what type and how many drinks in a typical week?

_____

Diet & Nutrition

Please list examples of foods you eat in a typical day:

Breakfast

_____

_____

Lunch

_____

_____

Dinner

_____

_____

Snacks

_____

_____

Drinks/Fluids

_____

_____

Food Sensitivities: ☐ No ☐ Yes
If yes, please list foods and symptoms:

_____

Food Aversions: ☐ No ☐ Yes
If yes, please explain:

_____

Special Diet or Restrictions (vegetarian, keto, carnivore, dairy-free, etc.): ☐ No ☐ Yes
If yes, please explain:

_____

Exercise & Sleep

Do you exercise regularly? ☐ No ☐ Yes

Describe your exercise routine:

_____

_____

_____

Average hours of sleep per night	☐ No ☐ Yes
Problems with insomnia	☐ No ☐ Yes
Problems falling asleep	☐ No ☐ Yes
Problems staying asleep	☐ No ☐ Yes
Snoring	☐ No ☐ Yes
Feel rested when awakening	☐ No ☐ Yes
Use sleeping aids	☐ No ☐ Yes

If yes, please explain:

_____

Stress & Lifestyle

Excessive stress in your life	☐ No ☐ Yes
Handling stress well	☐ No ☐ Yes
Use relaxation techniques	☐ No ☐ Yes

Relaxation Techniques Used:

☐ Meditation/Mindfulness ☐ Breathing ☐ Yoga ☐ Prayer ☐ Exercise

Other: _____

Do hobbies or leisure activities help with stress? ☐ No ☐ Yes

If yes, please explain:

_____

Family History

Any close relatives diagnosed with or deceased from heart disease, cancer, or other major medical issues at an early age?

☐ No ☐ Yes

If yes, please explain:

_____

_____

_____

Health Goals

☐ Optimize health and longevity

☐ Learn which supplements are best for me

☐ Improve overall health and energy

☐ Improve specific health problems or symptoms

Please explain your goals in more detail:

_____

_____

_____

_____

Please answer any of the following questions *if* you feel they are relevant to your situation:

When was the last time you felt well?

_____

_____

Did something trigger your change in health?

_____

_____

What makes you feel better?

_____

_____

What makes you feel worse?

_____

_____

How does your health condition affect you?

_____

_____

What do you think is happening and why?

_____

_____

What do you feel needs to happen for you to get better?

_____

_____

Is there anything not listed in this questionnaire that you think I need to know?

_____

_____

_____

Thank you for completing this form.
Douglas Farris, M.D.