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**First Visit Form for Adults**

*We look forward to your first visit in our office!* Please find a quiet moment to complete this form to bring to your appointment. We have carefully chosen these questions to address all aspects of your health. Your answers will help us to work with you in a way that best meets your health care needs. Feel free to skip any questions that you do not wish to answer. If there are questions that you prefer not to answer in writing but wish to discuss in-person, we may do so at your appointment.

**Today's Date:** \_\_\_\_\_

**First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_ **Last Name** \_\_\_\_\_

**Date of Birth** \_\_\_/\_\_\_/\_\_\_

**Phone Number** Home (\_\_\_\_) \_\_\_\_\_ Cell or pager (\_\_\_\_) \_\_\_\_\_  
Work (\_\_\_\_) \_\_\_\_\_

Where can we leave a confidential message? (circle one) Home Work Cell

**Email Address** \_\_\_\_\_

**Mailing Address** \_\_\_\_\_  
\_\_\_\_\_

**Emergency Contact** Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone Number Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

**Ethnicity:** (circle one) Latino Asian/Pacific Islander Black White Native American  
Other : \_\_\_\_\_

**Who referred you to Dr. Miller or Dr. Swan?** \_\_\_\_\_

Please describe the **major expectations** that you have of your family doctor:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list the names of **physicians and complementary medicine providers** who have treated you in the recent past:

Name	Telephone # (optional)	Profession/Specialty	Dates of treatment	
			From	To

Please list the names of **psychiatrists, psychologists, counselors and psychotherapists** who have treated you in the recent past:

Name	Telephone # (optional)	Profession/Specialty	Dates of treatment	
			From	To

What **medications and remedies** are you currently taking? This includes over-the-counter medications, homeopathic and herbal remedies, and nutritional supplements.

Name	Dose or quantity per day	When did you start it?

Do you have any **ALLERGIES** to medications? (circle one) YES NO

If yes, please describe \_\_\_\_\_

Please list any **hospitalizations or surgeries** you have had:

Reason for hospitalization or surgery	Date

What **exercise activities** do you do in a typical week?

Activity Type	Times per week	Minutes per time

Would you like to discuss your exercise regimen? (circle one) YES NO

What **foods** do you eat on a regular basis?

Breakfast foods	
Lunch foods	
Dinner foods	
Foods you crave	
Foods you dislike	
Snack foods	
Comfort foods	
Food allergies	

How many of your meals (including breakfast and lunch) each week are prepared in a restaurant? \_\_\_\_\_

Would you like to discuss your eating habits and diet? (circle one) YES NO

Do you consume any of the following?

	Yes	No	If yes, how much per week	If quit, when
Beer or wine				
Liquor				
Tobacco products				
Marijuana, cocaine or other drugs: (specify)				
Coffee, coke or other drinks with caffeine				

Do you feel that you have or had a problem with any of the substances listed above? (circle one) YES NO

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Overall do you feel that you get enough **sleep**? (circle one) YES NO

What time do you go to bed? \_\_\_\_\_ AM / PM

What time do you wake up? \_\_\_\_\_ AM / PM

What are the greatest sources of **stress** in your life? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What are the greatest sources of **comfort** in your life? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Who are the people, including members of your family, **who play a very important role in your life?**

Name	Relationship to you	Age	Where do they live?

Are you satisfied with your **personal relationships**? (circle one) YES NO

If you are a **parent**, do you have any concerns about parenting? (circle one) YES NO

If yes, please describe:

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Do you consider yourself heterosexual, homosexual, bisexual, transgender, other?

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Have you, or a close family member, ever experienced **sexual abuse or assault**?

(circle one) YES NO If yes, please explain: \_\_\_\_\_

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Do you use any form of **birth control** or **protection from sexually transmitted infections**?

(circle one) YES NO

If yes, please describe: \_\_\_\_\_

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Are you satisfied with your **sexual relationships**? (circle one) YES NO

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Do you belong to an **organized religion or spiritual group**? (circle one) YES NO

If yes, please describe:

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Are you currently a **student**? (circle one) YES NO

If yes, where? \_\_\_\_\_

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How many **years of education** have you completed? (circle one)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Do you have any **difficulties with learning**? (circle one) YES NO

If yes, please describe:

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What is your **job or occupation** \_\_\_\_\_  
Are you satisfied with your work? (circle one) YES NO  
Please describe: \_\_\_\_\_  
\_\_\_\_\_

Is there anything about your **work that negatively affects your mental or physical health?**  
\_\_\_\_\_  
\_\_\_\_\_

What is your current **annual household income?** (circle one)

\$20,000      \$20,000-\$40,000      \$40,000-\$60,000      \$60,000-\$80,000  
\$80,000-\$100,000      \$100,000-\$200,000      >\$200,000

Do you have any **concerns** about your current **FINANCIAL** situation? (circle one) YES NO  
If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any **concerns** about your current **LIVING** situation? (circle one) YES NO  
If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

<p><b>Women's Health:</b> Age of first menstrual period _____ Date of last menstrual period _____ Date of last: PAP _____ Pelvic exam _____ Mammogram _____ Breast exam _____ Have you ever had an abnormal PAP? (circle one) YES NO If yes, when _____ Number of pregnancies _____ Live births _____ Miscarriages _____</p>
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Is there **any other information** about you that you feel is important?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank You,

Daphne Miller, MD  
Avril Swan, MD  
Alex Zaphiris, MD

<b>Medical History</b> Please check the health problems that apply to each family member	S e l f	G r a n d p a r e n t	F a t h e r	M o t h e r	S i b l i n g	C h i l d	Please check all the <b>symptoms</b> that apply to you.	√
							Loss of Memory	
							General Weakness or Loss of Energy	
							Dizzy Spells, Fainting Spells or Blackouts	
							Frequent Headaches	
							Vision Disturbances	
Hearing Loss, Ringing in Ears								
Alcoholism							Ear pain or drainage	
Allergies/Hayfever							Nosebleeds	
Anemia							Sinus pains, Nasal Stuffiness	
Arthritis/Rheumatism							Frequent Sore Throat, Tonsillitis	
Asthma							Hoarseness	
Birth Defects							Swollen Glands	
Bleeding Disorders							Shortness of Breath	
Cancer or Tumor							Frequent Coughs, Wheezing	
Colitis or Crohn's							Palpitations, Chest Pains, Rapid Heartbeat	
Congenital Heart Disease							Anxious Feeling in Chest or Stomach	
Depression							Poor Appetite	
Diabetes							Indigestion	
Emphysema, COPD							Abdominal Pain, Discomfort, Bloating	
Epilepsy, Seizures							Constipation, Use of Laxatives	
Frequent Infections							Diarrhea, Bloody Stools	
Genetic Disease							Rectal Pain, Itching, Irritation	
Glaucoma, Cataracts							Hemorrhoids, Anal Fissures	
Gonorrhea/Chlamydia							Difficulty Urinating	
Gout							Urinary Incontinence	
Herpes							Burning with urination	
Heart Disease/Heart Attacks							Frequent urination	
High Blood Pressure							Breast pain or discharge	
HIV, AIDS							Breast lumps	
Infertility							Pain with intercourse	
Kidney Disease							Men: Penis or testicle problem	
Liver Disease, Hepatitis							Men: Difficulty maintaining an erection	
Mental Illness							Women: Irregular or painful periods	
Migraine Headaches							Women: Premenstrual tension/mood swings	
Nervous Breakdown							Women: Vaginal Itch or odor	
Obesity							Women: Vaginal dryness	
Osteoporosis							Swollen or painful legs	
Peptic Ulcer Disease							Back Pain, Sciatica	
PID							Joint Pain, Joint Swelling	
Prostate Problems							Skin discoloration, rashes, sores, moles	
Psoriasis, Eczema							Severe perspiration, nightsweats	
Rheumatic Fever							Nightmares, Recurrent Dreams	
Stroke							Fears or Phobias	
Suicide (or attempted)							Anxiety or Nervousness	
Thyroid Disease							Angry, Irritable, Impatient, Critical	
Tuberculosis							Sadness, Grief, Depression	
other							other	