Patient Name: _____

Date: _____ **Height:** _____

Age: _____ **Weight:** _____

DOB: _____ **BMI *(Dr. will calculate)*:** _____

List in Order of Importance Chief Concerns/Health Goals:

1)_____

2)_____

3)_____

4)_____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age (if Living):	_____	_____	_____	_____	_____	_____
Age Deceased:	_____	_____	_____	_____	_____	_____
Cause of Death:	_____	_____	_____	_____	_____	_____
Cancer (list type):	_____	_____	_____	_____	_____	_____
High Blood Pressure:	_____	_____	_____	_____	_____	_____
Heart Attack/ Stroke	_____	_____	_____	_____	_____	_____
Asthma/Allergies:	_____	_____	_____	_____	_____	_____
Mental Illness:	_____	_____	_____	_____	_____	_____
Autoimmune dz:	_____	_____	_____	_____	_____	_____

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	Father	Mother	Siblings	Grandparents	Spouse	Children
Diabetes:	_____	_____	_____	_____	_____	_____
Osteoporosis:	_____	_____	_____	_____	_____	_____
Addictions:	_____	_____	_____	_____	_____	_____
Alzheimer's/Demetia:	_____	_____	_____	_____	_____	_____

Childhood Health

Were you born vaginally or by C section? _____

Were you breast fed? _____

Did you have any recurrent health issues as a baby or child?
_____

Where did you grow up? _____

Medical History

List All Surgeries and Hospitalizations, including dates:
1)_____ 2) _____

3) _____ 4) _____

Medications Used in the *Past* (Please describe all medications that you can recall being prescribed, including the approximate dates and duration):
_____

_____

_____

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Please Note *When* and *Why* You Have Had Each of the Following:

X-Rays _____ MRI/CTScan _____

Ultrasounds_____ Accidents_____

HIV_____ HCV_____

Last Eye Exam_____ Last Dental Visit_____

Please List *Yes, No*, or *Past* regarding use of the following:

Antacids: Y N P **Steroids: Y N P** **Analgesics: Y N P**

Cigarettes: Y N P **Packs per day:____** **Number of Years:____**

Coffee: Y N P **Cups per Day:_____** **Soda: Y N P Cups per Day:_____**

Alcohol: Y N P **How much and how often:_____** **Alcohol Addiction: Y N P**

Alcohol Treatment:_____ **Recreational Drugs:_____** **Drug Treatment:_____**

Please List All prescription *Medicines*, *Supplements*/*Herbs* that you are currently taking *including dosage:*

_____

_____

_____

_____

_____

_____

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Diet

Please describe a *typical day*, and please be honest!:

Breakfast:_____

Snack:_____

Lunch:_____

Snack:_____

Dinner:_____

Dessert:_____

Beverages:_____

What types of foods do you crave?_____

If you could eat one thing every day without care over calories, what would that be?_____

What foods are you averse to?_____

Do you have any foods that make you feel ill when you eat them?_____

Do you crave sweets often?_____

When you do crave sweets, how do you satisfy the craving?_____

Do you like to cook? Y N

How often do you eat out? Twice per Day Once per Day Once or Twice a Week Never

Are you interested in learning how to cook healthy, delicious food? Y N

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Present Weight:_____ Height:_____

Maximum Weight and When:_____ Ideal Weight:_____

For the rest of the questions, Please circle Y (yes), N (no), or P (past)

Skin

Rash: Y N P **Color Change: Y N P**

Hives: Y N P **Lump(s): Y N P**

Psoriasis/Eczema: Y N P **Itchiness: Y N P**

Dry: Y N P **Warts/moles: Y N P**

Cancer: Y N P **Perspiration: Y N P**

Head

Headache: Y N P **Migraine: Y N P**

Dandruff: Y N P **Head Injury: Y N P**

Oily/dry hair: Y N P **Hair loss: Y N P**

Nose

Frequent Colds: Y N P **Nosebleeds: Y N P**

Congestion: Y N P **Post Nasal Drip: Y N P**

Polyps: Y N P **Seasonal Allergies: Y N P**

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Eyes

Dry/ Watery: Y N P

Blurry Vision: Y N P

Double Vision: Y N P

Catartacts: Y N P

Glaucoma: Y N P

Styes: Y N P

Strain: Y N P

Discharge: Y N P

Itchy: Y N P

Dark under eyes: Y N P

Mouth/Throat

Canker Sores: Y N P

Cold sores: Y N P

Sore throat: Y N P

Bleeding Gums: Y N P

Dentures: Y N P

Cavities: Y N P

Loss of Taste: Y N P

Hoarseness: Y N P

Neck

Stiffness: Y N P

Swollen Glands: Y N P

Restricted Movement: Y N P

Tension: Y N P

Respiratory

Cough: Y N P

TB: Y N P

Shortness of Breath: Y N P

Bronchitis: Y N P

Pneumonia: Y N P

Asthma: Y N P

Wheezing: Y N P **Painful Breathing: Y N P**

Cardiovascular

High Blood Pressure: Y N P **Rheumatic Fever: Y N P**

Low Blood Pressure: Y N P **Murmurs: Y N P**

Arrhythmias: Y N P **Palpitations: Y N P**

Edema: Y N P **Chest Pain: Y N P**

Urinary Tract

Incontinence: Y N P **Pain w/ urination: Y N P**

Frequent Infections: Y N P **Kidney Stones: Y N P**

Urgency: Y N P **Discharge/ Blood: Y N P**

Gastrointestinal

Heartburn: Y N P **Daily Bowel Movements: Y N P**

Indigestion: Y N P **Recent Change in BM: Y N P**

Bloating: Y N P **Diarrhea/Constipation: Y N P**

Vomiting: Y N P **Hemorrhoids: Y N P**

Change in Appetite: Y N P **Gall Bladder Disease: Y N P**

Pancreatitis: Y N P **Liver Disease: Y N P**

Ulcer: Y N P

Male Genitalia

Testicular Pain/Swelling: Y N P **Sexually Active: Y N P**

Hernia: Y N P **STD: Y N P**

Discharge: Y N P **Prostate Disease: Y N P**

Difficulty with Urination: Y N P **Impotency: Y N P**

Female Genitalia

Age Period Began:_____ **How Often Period Occurs:_____**

How Long Period Lasts: _____ **Heavy Menstrual Bleeding: Y N P**

Menstrual Cramping: Y N P **Menstrual Pain: Y N P**

PMS: Y N P **Food Cravings: Y N P**

Pregnancy: Y N P How many: _____ **Miscarriages: Y N P**

Last Pap Smear: _____ **Abortions: Y N P**

Abnormal Pap: Y N P **Menopausal: Y N Since What Age:_____**

Menopausal Symptoms:_____

Use of Hormones: Y N P **Healthy Libido: Y N P**

Vaginal Dryness: Y N P **Sexually Active: Y N P**

Pain w/ Intercourse: Y N P **Vaginitis: Y N P**

STD: Y N P If yes, please list: _____

Last Mammogram: _____ Ever an abnormal mammogram?_____

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Any family or personal history of breast, uterine, or ovarian cancer?_____

Last Dexa Scan:_____ What were results?_____

Please list any birth control and ages used:_____

Musculoskeletal

Weakness: Y N P **Arthritis: : Y N P**

Stiffness: : Y N P **Leg Cramps: : Y N P**

Tremors: : Y N P **Pain: : Y N P**

Nervous

Paralysis: : Y N P **Sciatica: : Y N P**

Tingling/Numbness: : Y N P **Carpal Tunnel Syndrome: : Y N P**

Seizures: : Y N P **Fainting: : Y N P**

Mental/Emotional

Depression: : Y N P **Anger/irritability: : Y N P**

Suicidal: : Y N P **High strung/tense: : Y N P**

Anxiety: : Y N P **Fear/Panic: : Y N P**

Eating disorder: : Y N P **Psych hospitalization: : Y N P**

Do you have a strong community that you feel supports you? Y N

Are you close with your family? Y N

Any history of physical, emotional, or sexual abuse? Y N

Exercise

How often do you exercise:_____ For how many minutes?_____

What type of exercise do you prefer?_____

Do you feel like you are in good shape?_____

What are you hobbies and talents?_____

Sleep

How many hours do you sleep per night?_____

Do you fall asleep easily?_____

Do you wake during the night? Y N If so, how often?_____

Do you wake feeling refreshed? Y N Do you nap during the day?_____

Do you get sleepy in the afternoons?_____

Toxin Exposure

Have you ever had any toxic exposures that you are aware of? Y N

Have you ever lived near a refinery, a farm, or a polluted area? Y N

Did you grow up in a house built before 1976 that had lead paint? Y N

Have you ever lived in a house with any known water leaks\damage? Y N

Do you have any known mold exposure? Y N

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Do you use solvents in any of your work or hobbies?_____

Have you ever experienced health problems after putting in new carpeting, new paint, or any other refurbishing in your home? Y N

Have you ever smoked cigarettes? Y N

Did your parents or spouse smoke cigarettes in the house? Y N

Are you sensitive to medications? Y N Do you easily experience adverse effects?_____

How often do you eat fish? _____

How often do you eat tuna? _____ Have you eaten it a lot in the past? Y N

Are you very sensitive to caffeine?_____

Are you sensitive to smells? Y N What happens?_____

Do you use pesticides, herbicides, or other chemicals in your home?_____

Do you have mercury fillings in your mouth? Y N How many?_____

Have you ever worked for the airline industry? Y N For how long?_____

Do you frequently experience BRAIN FOG, or dis-ordered memory? Y N

What foreign countries have you travelled to?
_____

Have you ever gotten sick in a foreign country? Y N

What kind of career do you have?_____

Do you enjoy you job?_____

What are your hobbies?_____

Social Life

Are you in a relationship? Y N Are you happy with your relationship (or lack of)? Y N

Do you consider yourself to be a happy person?_____

How do you rate your levels of stress? High Moderate Little None _____

When you look back on your life, what was your happiest time?_____

How committed to your health are you?_____

Do you believe that you are going to get better? Y N

What challenges do you expect to face in your process of moving to your ideal health?_____

Is there anything else that you would like me to know?
_____
_____
_____

Thank you for being open and thorough in completing this! All of this information helps me to get to know you as thoroughly as I can from the beginning of our work together. This will maximize time that we have together.

A few words about what you can expect from our work together: One of the things that I love about naturopathic medicine is that the doctor educates and guides the patient along their healing process, but YOU (the patient) are the main driving force in your healing process. In order to make real improvements in your health, YOU need to be pro-active and committed.

I am looking forward to working together!

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