

MEDICAL HISTORY (ADULT)

Date: _____

Patient Name: _____ Date of Birth: _____

Home Address: _____ Female Male
Street

City State Zip Code Occupation: _____

Phone: _____
Home Work/Cell Email

Martial Status: Married Separated/Divorced In relationship Widowed Single

Do you have any children? If yes, please include names, gender & age?

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____ Phone: _____

How did you hear about us? _____

Have worked with a Naturopathic Doctor in the past? _____ If yes, when? _____

List in order of importance of your health concerns:

- 1) _____
- 2) _____
- 3) _____

List any allergies (medications, foods):

Do you have health insurance? If yes, who's the carrier: _____

Last Physician Exam: _____ Physician & Phone #: _____

Last Dental Exam: _____ Dentist & Phone #: _____

Last Vision Exam: _____ Do you wear corrective lens: No Glasses Contact lens

Last Hearing Exam: _____ Do you have a hearing aid(s): Both Right Left

Last Lab/Blood Work-Up/Test: _____

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X-rays, Ultrasounds, MRI/CT Scan:

Imaging	Reason for Image	Date of Image
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Surgeries & Hospitalizations:

Type of surgery	Reason for surgery	Date of surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all **current** medications & dosages (including herbs, supplements, Over-the-Counter):

Medication/Supplements & Dose	Reason for Med/Supplements	How long you've been taking it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Family History: Please check (✓) if any family member(s) have had any of the following health conditions

MGF: maternal grandfather

MGM: maternal grandmother

PGF: paternal grandfather

PGM: paternal grandmother

Medical Conditions:	Father	Mother	Siblings	Children	Grandparents			
					MGF	MGM	PGF	PGM
If Living: Age								
If Deceased: Age & Cause								
High Blood Pressure								
Heart Attack/Stroke								
Heart Disease								
High Cholesterol								
Thyroid Disease								
Asthma/Allergies								
Tuberculosis								
Auto-Immune Disease								
Diabetes Mellitus								
Hepatitis								
Osteoporosis								
Cancer								
Depression								
Mental Illness								
Addiction/Alcoholism								
Glaucoma								
Cataracts								
Other:								
Other:								

Vaccination History: Please check (✓) if you have had disease, got immunized or was never exposed

	Measles	Mumps	Rubella	Tetanus	Whooping cough	Hemophilus (Hib)	German measles	Chicken pox (varicella)	Hepatitis B	Pneumonia	Flu
Had Disease											
Got immunized											
Never Exposed											

Have you had any vaccination reactions? If yes, what happened? _____

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Social History/Lifestyle: Please circle Yes (Y), No (N), or Past (P) for the following:

Antacids:	Y	N	P	Steroids:	Y	N	P	Antibiotics:	Y	N	P
Analgesics:	Y	N	P	Laxatives:	Y	N	P				
Coffee:	Y	N	P	Cups per day if Yes/Past:	_____						
Caffeine/tea:	Y	N	P	What kind & How much per day:	_____						
Soda:	Y	N	P	Ounces per day if Yes/Past:	_____						
Alcohol:	Y	N	P	How often & how much if Yes/Past:	_____						
Any Alcohol Addiction:	Y	N	P	Any Alcohol Treatment:	Y	N	P				
Smoking:	Y	N	P	Packs per day & number of years:	_____						
Recreational Drugs:	Y	N	P	Any Drug Addictions:	Y	N	P	Any Drug Treatment:	Y	N	P

Are you sexually active? _____ If yes, what is your chosen form of protection? _____

Do you exercise? If yes, how long and often? _____

Sleep Pattern:

How many hours of sleep do get at night? _____ Bed time: _____ Wake-up time: _____

Do have interrupted sleep pattern or wake up in the middle of the night? If yes how often? _____

Do you feel refreshed upon waking in the morning? If no, how long does it take for you to wake up? _____

Do you need caffeine to wake up in the morning: _____

Do you need to take naps during the day? If yes, how long is your nap? _____

Please circle Yes (Y), No (N), or Past (P) for the following:

Do you snore	Y	N	P	Grind your teeth	Y	N	P	Sleep Walk	Y	N	P
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Energy: Please rate your energy level on the scale: 1 (no energy)—10 (abundant)

Morning: _____ Afternoon: _____ Evening: _____

Overall average daily: _____

Environmental Exposures:

Did you grow up near any refinery, polluted area or in a home with leaded paint or mold? If yes, what type of pollutants?

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you experienced health problems exposed to new carpeting, painted your home, had new cabinets, etc? _____

Are you sensitive to fragrance from perfumes, gasoline or other vapors? _____

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

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Review of Systems: Please check (✓) if you experienced the symptoms in the Past (P) and Current (C)

General

P C

- Recent weight change
-
- Fever
- Chills
- Allergies (seasonal)
- Weakness
- Fatigue
- Night sweats
- Frequent Cold/Flu
- Cancer

Head

P C

- Headache
- Migraine
- Head injury
- Dizziness
- Lightheadedness
- Dandruff
- Oily scalp
- Dry scalp
- Hair loss

Eyes

P C

- Recent vision changes
- Dryness
- Watery
- Discharge
- Itchy
- Strain
- Pain
- Double vision
- Blurry vision
- Cataracts
- Glaucoma
- Styes

Ears

P C

- Recent hearing changes or loss
- Tinnitus/ ringing
- Vertigo/dizziness
- Infection
- Discharges
- Earaches
- Ear tubes
- Hearing aids

Nose

P C

- Frequent colds
- Nasal congestion
- Nosebleed
- Postnasal drip/nasal discharge
- Sinus problem
- Hay fever/seasonal allergies
- Nasal polyps
- Decreased or Lost of smell
- Fracture or Surgery

Mouth/Throat

P C

- Canker sores
- Cold sores
- Dry mouth
- Loss of taste
- Dental problems: cavities
- Dentures
- Amalgam filling, root canal
- Gum disease/Bleeding gums
- Hoarseness
- Sore throat
- Difficulty swallowing

Neck

P C

- Stiffness/Pain/Tension
- Injury
- Swollen glands

Respiratory/Lungs

P C

- Cough
- Shortness of breath
- Cough with blood
- Rapid breathing
- Wheezing
- Asthma
- Bronchitis
- COPD
- Pneumonia
- TB
- Sleep apnea
- Painful breathing

Cardiovascular/Heart

P C

- High blood pressure
- Low blood pressure
- Chest pain
- Arrhythmias/irregular heartbeat
- Palpitations
- Edema
- Varicose vein
- Heart murmur
- Rheumatic fever

Skin

P C

- Rash, Hives
- Sores
- Eczema
- Psoriasis
- Dryness
- Itchiness
- Acne
- Cancer
- Moles
- Warts/Herpes
- Color change
- Easily bruising/bleeding

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Gastrointestinal

P C

- Change in appetite
- Difficulty with swallowing
- Food intolerance/sensitivity
- Nausea or vomiting
- Vomit with blood
- Regurgitation
- Heartburn
- Indigestion
- Bloating
- Gas/flatulence
- Abdominal pain
- Ulcers
- Crohn's
- Constipation
- Diarrhea
- Kidney disease
- Liver disease
- Liver disease
- Jaundice
- Gall bladder disease
- Hepatitis
- Pancreatitis
- Hernia
- Hemorrhoids
- Rectal bleeding
- Bloody stool
- Cancer
- Abnormal changes in bowel

of bowels per day: _____

How does bowel look like: _____

Urinary Tract

P C

- Incontinence
- Bladder or kidney stones
- Bladder infection/cystitis
- Frequent infection: UTI
- Pain/burning with urination
- Discharge/blood in urine
- Urinary urgency & frequency

Female

P C

- PMS
- Painful (cramps) menses
- Irregular menses
- Heavy menstrual bleeding
- Vaginal discharge
- Vaginal dryness
- Vaginal itchiness
- Yeast infection
- Vaginal sores or lumps
- Sexually transmitted disease
- Cancer
- Healthy Libido
- Pain with intercourse
- Menopausal Symptoms

Age of menarche: _____

Date of last menses: _____

of days: _____

Length of cycle: _____

Date of last PAP smear: _____

Any history of abnormal PAP? _____

Current birth control method: _____

Are you pregnant? If yes, how far along? _____

How many pregnancy? _____

How many live births? _____

How many abortions? _____

Age of Menopause? _____

Last Dexa Scan: _____

Breast

P C

- Nipple discharge
- Painful, tenderness
- Mass, tumor
- Change in size or color
- Cancer

Do you do regular self-breast exam: _____

If yes, how often? _____

Last Mammogram: _____

Male

P C

- Discharge from penis
- Sores or lumps on penis
- Hernia
- Testicular pain or swelling
- Sexually transmitted disease
- Sexually active
- Prostate inflammation/disease
- Cancer

Last PSA: _____

Last Prostate Exam: _____

Musculoskeletal

P C

- Weakness
- Stiffness
- Muscle or joint pain
- Arthritis
- Leg cramps
- Gout
- Bone pain
- Injury

Neurological

P C

- Paralysis
- Tingling/Numbness
- Tremors
- Seizures
- Sciatica
- Carpal Tunnel Syndrome
- Difficulty concentrating
- Memory Loss
- Fainting
- Vertigo

Endocrine

P C

- Thyroid dysfunction
- Diabetes
- Hot/Cold intolerance
- Frequent/urgency urination
- Night sweats

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Mental/Emotional

P C

- Depression
 - Bipolar
 - Suicidal thoughts
 - Suicidal attempts
 - Anxiety/Nervousness
 - Anger/Irritability
 - Phobia
 - Eating disorder
 - ADHD, ADD, Autism,
 - Under supervision of psychiatrist
 - Working with a counselor or therapist
 - Taking medications of psychiatric disorder. Name of medication and how long on medications:
-

Diet:

How much water do you drink a day? _____

What are your cravings? _____

What are your food intolerance/sensitivities?

Are you on a specialize diet for health or weight loss? If yes, what kind of diet & how long?

What is time is your last meal for the day: _____

What does your typical diet look like:

Meal times	List of foods
Breakfast	
Lunch	
Dinner	
Snacks	
Other	