MEDICAL HISTORY (ADULT)

Date:_____

Patient Name:_____ Date of Birth:_____

Home Address: _____ ☐ Female ☐ Male
Street

_____ Occupation:_____
City State Zip Code

Phone: _____ _____ _____
Cell Home/Work 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

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	