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: ______________________________

MEDICAL HISTORY (ADULT)

Patient Name:____ Date of Birth:_______________

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** **<u>MEDICATIONS</u>** & dosages (including Over-the-Counter):

Medication & Dose	Reason for Medications	How long you've been taking it

MEDICAL HISTORY (ADULT)

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List all **current** **SUPPLEMENTS** & dosages (including herbs, homeopathy, Over-the-Counter,etc):

Supplements & Dose	Reason for 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	Pneuomonia	Flu
Had Disease											
Got immunized											
Never Exposed											

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

MEDICAL HISTORY (ADULT)

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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? ____

MEDICAL HISTORY (ADULT)

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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

MEDICAL HISTORY

Patient Name:______________________________ Date of Birth:________________

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

MEDICAL HISTORY

Patient Name:______________________________ Date of Birth:______________

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	