



In Health Naturopathic Medicine

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Confidential

HEALTH HISTORY

Patient Name: _____ Today's Date: _____
Age: _____ Birth date: _____ Day of Last Physical Examination: _____
What is the reason for your visit?: _____

Conditions

What, if any, serious conditions have you experienced in the past year?: _____

If there isn't enough space, please provide an attached list of all allergies, medications, and supplements.

Medications/Supplements	
Medication Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

Pharmacy Name: _____ Phone: (_____) - _____

Symptoms

Check the box if you currently have or have had any of these symptoms in the past year:

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <p>GENITO/URINARY</p> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Lack of Bladder Control <input type="checkbox"/> Painful Urination <p>SKIN</p> <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Hives/Itching <input type="checkbox"/> Changes in Moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sores that don't heal	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Poor appetite <input type="checkbox"/> Bloating/Gas <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling in the ankles <input type="checkbox"/> Varicose veins <input type="checkbox"/> Other: _____	<p>EYE/EAR/NOSE/THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred/double vision <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision flashes/Halos <p>MEN ONLY</p> <input type="checkbox"/> Breast lumps <input type="checkbox"/> Difficulty with erections <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Sore penis <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Other: _____	<p>WOMEN ONLY</p> <input type="checkbox"/> Abnormal PAP smear <input type="checkbox"/> Bleeding between cycles <input type="checkbox"/> Breast lumps <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Loss of Libido/sex drive <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal pain <input type="checkbox"/> Other: _____ <p>Date of Last Menstrual Period: _____</p> <p>Date of Last Pap: _____</p> <p>Last Mammogram: _____</p> <p>Are you Pregnant? _____</p> <p>Number of Children: _____</p>
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FAMILY HISTORY; Fill in health information about your immediate family

Relation	Age	Gender	State of Health	Age At Death	Cause of Death	Check if, Your blood relative had any of the following	
Mother						<input type="checkbox"/> Disease	Relationship to you
Father						<input type="checkbox"/> Arthritis, Gout	
Siblings						<input type="checkbox"/> Asthma, Hay Fever	
						<input type="checkbox"/> Cancer	
						<input type="checkbox"/> Chemical Dependency	
						<input type="checkbox"/> Diabetes	
						<input type="checkbox"/> Heart Disease, Stroke	
						<input type="checkbox"/> High Blood Pressure	
						<input type="checkbox"/> Kidney Disease	
						<input type="checkbox"/> Tuberculosis	
						<input type="checkbox"/> Other:	

IMPORTANT HOSPITALIZATIONS; In the past 10 years

Year	Hospital	Reason

PREGNANCIES; Attach list if more than 5 births

Year Of Birth	Sex of Birth	Complications, If Any

HEALTH HABITS

<input type="checkbox"/>	Substance	How much
<input type="checkbox"/>	Caffeine	
<input type="checkbox"/>	Tobacco	
<input type="checkbox"/>	Recreational Drugs	
<input type="checkbox"/>	Alcohol	

OCCUPATIONAL

<input type="checkbox"/>	Name Of Occupation:
<input type="checkbox"/>	Stress
<input type="checkbox"/>	Heavy lifting
<input type="checkbox"/>	Hazardous Substances
<input type="checkbox"/>	Other

I, _____, acknowledge and agree that I have read a copy of the physician's Notice of Privacy Practices and that a copy can be provided upon request. I, _____, also to my knowledge have filled out the above form With health history information is complete and correct. I understand that is my responsibility To inform the physician in charge of my care if I, or my minor child, ever have a change in health

Signature of Patient, Parent, Guardian, or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient