



# 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><b>GENERAL</b></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><b>GENITO/URINARY</b></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><b>SKIN</b></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><b>GASTROINTESTINAL</b></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><b>CARDIOVASCULAR</b></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><b>EYE/EAR/NOSE/THROAT</b></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><b>MEN ONLY</b></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><b>WOMEN ONLY</b></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