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Name _____ Age ____ D.O.B. _____ Date _____
Address _____ City _____ State ____ Zip _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Is it OK to leave a message at these phone numbers? Home Y N Work Y N Cell Y N
Occupation _____ Full or Part Time _____
Employer (Name and Address)
_____
Education _____ Referred by _____
Live with: Spouse/Partner ___ Parents ___ Relatives ___ Friends ___ Alone ___ Other ___
Next of Kin (or emergency name) _____ Relationship _____
Address _____
Telephone (Home) _____ (Work) _____

NOTE: Naturopathic and Preventive health care are only possible when the physician has a complete picture of the patient physically, mentally and emotionally. Therefore, please complete this health questionnaire as thoroughly as possible.

What other health care are you presently receiving? _____
_____
What are your most significant health problems? List in order of importance.
1._____
_
2._____
3._____
_
4._____
_
5._____
_
What are your health goals?
1._____
_
2._____
_
3._____
_
4._____
_

PAST MEDICAL HISTORY
Health as a child? Good _____ Fair_____ Poor _____
What childhood illnesses have you had?
Rubella (German 3 day measles)___ Measles (2 week)___ Mumps___ Chickenpox___ Roseola___
Whooping cough___ Polio___ Rheumatic Fever___ Scarlet Fever___ Asthma___ Eczema___
Diphtheria___ Other_____

VACCINATIONS
___Chicken Pox ___Diphtheria ___Polio

___Hepatitis B ___Tetanus (not antitoxin) ___Hemophilus Influenza (HIB)
___Pertussis ___Measles/Mumps/Rubella (MMR)
Other _____

HOSPITALIZATIONS

Type of illness or operation/procedure Date Hospital

_____ _____
_____
_____ _____
_____
_____ _____
_____

MEDICATIONS - List all drugs, vitamins, herbs and supplements being taken at present with dosage.

_____
_____
_____
_____
____

ALLERGIES

Are you allergic to any **medications**? Y N
If yes, please list _____
_____
What happens when you have an allergic reaction? _____
Are you allergic to any **foods**? Y N
If yes, please list _____
_____
What happens when you have an allergic reaction? _____

FAMILY HISTORY - Please list ages and if deceased, what they died from and at what age.

Mother's Side
Grandfather _____
Grandmother _____
Mother _____

Father's Side
Grandfather _____
Grandmother _____
Father _____

Sisters _____
Brothers _____

Has any **Blood Relative** had any of the following:

___Anemia ____Eczema ____Seizures/Epilepsy
___Arthritis ____Glaucoma ____Sickle Cell Anemia
___Asthma ____Gout ____Stroke
___Bleeding (easily) ____Hay fever ____Thyroid (hyper/hypo)
___Cancer (type)_____ ____Heart attack ____Tuberculosis (TB)
___Diabetes ____High Blood Pressure
Other (specify)_____

HEALTH HABITS:

Substance use: Caffeine Y N Tobacco Y N Alcohol Y N Recreational Drugs Y N
How much water do you drink each day?_____
Do you exercise? _____ What form(s)
_____
How long?_____ How often?_____
How do you relax?
_____

What are your primary interests or hobbies?_____
_____
_____

DIET

Number of meals eaten per day: 1 2 3 more than 3
List any of the foods you crave (including sweets, chocolate, salty, sour, bread, rich/fatty, foods, etc.):
_____
List any foods you exclude from your diet._____
_____
List any foods to which you have a bad reaction :
_____
_____
Are you satisfied with your diet as it is now? ____ If not, why not?
_____
_____

SLEEP

Do you sleep well? Y N Do you wake rested? Y N How many hours do you sleep?_____
Do you have trouble falling asleep? Y N Do you sleep straight through the night? Y N

HEALTH HISTORY

Have you ever been diagnosed with or suffered from any of the following conditions?

___Allergies
___Anemia
___Arthritis
___Asthma
___Alcoholism
___Bleeding disorder
___Cataracts
___Cancer*_____
___Candida (yeast)
___Colitis
___Diabetes
___Eczema
___Emphysema
___Epilepsy
___Gout
___Glaucoma
___Headache/migraines
___Heart disease
___Heart murmur*
_____
___High blood pressure
___HIV
___Kidney disease
___Liver disease/jaundice
___Multiple sclerosis
___Pneumonia
___Polio
___Rheumatic fever
___Stroke
___Sexually transmitted disease*
_____
___Thyroid (hyper/hypo)*
___Tuberculosis

Others (specify)_____

SYMPTOMS

____Pain in ears
____Ringing in ears
____Discharge in ears
____Hearing loss
____Dizziness
____Dry eyes, nose and/or mouth
____Eyelids swollen/puffy
____Poor eyesight: near/far (circle one)
____Light hurts eyes
____Double vision
____Nose bleeds
____Loss of sense of smell
____Sinus congestion
____Bad breath
____Bad taste in mouth
____Sore mouth or tongue
____Cold sores, herpes
____Loss of teeth
____Receding/bleeding gums
_____Number of silver/mercury fillings
____Chronic sore throat
____Loss of voice
____Difficulty swallowing
____Recurrent strep throat
____Skin rough, dry, scaly, bumpy, itchy (circle)
____Rashes, warts, moles, cysts (circle)
Have any of these changed in size or color recently?
_____
Would you like to have any of these removed? _____
____Light or dark patches of skin (circle)
____Nails: Color changes, ridges, pits, white spots (circle)
____Hives. List what causes them_____
_____

____Backaches
____Joint pain/ stiffness/ swelling specify_____
____Muscle/leg/toe cramps
____Arthritis
____Stiffness
____High blood pressure
____Pulse slow/irregular
____Poor circulation
____Loss of balance/fainting
____Low blood pressure
____Dizziness upon standing
____Chest pain when walking
____Leg pain when walking
____Leg vein problems
____Ankle swelling
____Shortness of breath
____Difficulty breathing at night (wakes you up)
____Heart palpitations: flutter, missed beat, beating fast/slow (circle)
____Daily cough
____Wheezing
____Chest congestion
____Chest pain when breathing
Have you ever been exposed to T.B. (tuberculosis)? _____
When was your last T.B. test? _____
When was your last chest X-ray? _____
Reason? _____
Results? _____
____Bruising easily
____Frequent/severe nausea
____Frequent vomiting
____Excessive belching, stomach cramps, colic, gas (circle)
____Abdominal bloating/ distention
____Stomach/abdominal pain
____Distress from fatty or greasy foods
_____Frequency of bowel movements per day/per week
____ Increased/decreased appetite
____Heartburn
____Constipation
____Diarrhea
____Alternating constipation and diarrhea
____Indigestion/pain after eating a meal
____Heavy, full after eating
____Change in bowel movements
____Straining with stools
____Hemorrhoids
____Ulcer/colitis (circle)
____Blood in stools
____Stools: yellow, gray, green, foul odored, black, undigested food (circle)
____Severe headaches/migraines
____Fainting spells
____Seizures, convulsions
____Perspiration scant/excessive
____Pain, numbness, tingling while coughing, sneezing or straining at stools
____Burning on soles of feet or palms of hands (circle)
____Tremor (shaking, trembling)
____Lack of strength (body area)
____Paralysis
____Cold sweats
____Numbness/tingling in extremities
____Painful lymph nodes
____Swollen glands
____Unexplained fever
____Night sweats
____Frequent urination
____Painful urination
____Night urination
____Difficult starting/stopping urine
____Difficulty holding urine
____Blood in urine
____Repeated kidney or bladder infections (circle)
____Easily fatigued
____Flushed, get hot easily
____Unexplained weight loss/gain
____Cold hands or feet
____Intolerant of hot/cold weather
____Weakness
____Wounds heal slowly
____Crave salt
____Increased thirst
____Low sugar tolerance
____Nervous, shaky with headaches relieved by food
____Irritable if late for a meal, miss meal or before breakfast
____Diet but fail to lose weight
____Eat but fail to gain weight
____Over/underweight
____Compulsive eating
____Anxiety
____Very quick mentally
____Memory difficult, forgetful
____Mental slowness
____Irritable/restless
____Decreased concentration and comprehension
____Excessive excitement
____Depression
____Despair/Discontent
____Shy, Timid
____Suicidal thoughts
____Suicidal attempt

Reproductive

____Lumps in breast
____Painful intercourse
____Nipple discharge
____Breast pain
____Pelvic pain
____Discharge from vagina
____Vaginal itching/burning
____Menstruation absent
____Menstruation excessive
____Genital eruptions
_____ Type?
____Bleed or spot between periods?

Have you ever used birth control pills? _____ For how long? _____

Are you currently sexually active? _____ Have you been sexually active in the past? _____
Current form/s of contraception _____
Ages when menstrual periods began _____ ended _____
Period every _____ days. Regular: Yes No
Periods usually last _____ days (average) Date of last period _____
Date of last PAP smear _____ Was it normal? _____ If not, explain _____
Do you currently, or have had in the past, problems with infertility _____ If yes, explain _____
_____
Number of: pregnancies _____ births _____ miscarriages _____ abortions _____
Any complications of pregnancy? _____ If yes, explain
_____

Thank You For Your Cooperation, Patience and Thoroughness