

Health Questionnaire **Please fill out both sides of this form**

Name: _____ Date of Birth: _____

REASON FOR VISIT: _____

GOALS FOR TODAY: _____

HAVE YOU EVER CONSULTED A NATUROPATHIC PHYSICIAN BEFORE? Yes No

FAMILY HISTORY

ADOPTED? YES NO If yes, please fill out information for biological relatives if known.

IF ANY IMMEDIATE FAMILY HAS HAD ANY OF THE FOLLOWING - PLEASE CIRCLE THE # AND INDICATE RELATIVE

1) ALCOHOLISM	7) CANCER (SPECIFY)	13) HEART DISEASE	
2) ALZHEIMER'S	8) CHOLESTEROL HIGH	14) HYPERTENSION	
3) ANEMIA	9) DIABETES	15) MENTAL ILLNESS	
4) ARTHRITIS	10) EPILEPSY	16) MIGRAINE	
5) ASTHMA	11) GLAUCOMA	17) OSTEOPOROSIS	
6) BLEEDS EASILY	12) HAYFEVER	18) THYROID	
OTHER:			

FATHER	Living?	YES NO	Present health or cause of death:		
MOTHER	Living?	YES NO	Present health or cause of death:		
SPOUSE	Living?	YES NO	Present health or cause of death:		
BROTHERS	# Alive		Health:	# Deceased:	Cause of death:
SISTERS	# Alive:		Health:	# Deceased:	Cause of death:
CHILDREN	# Alive:		Health:	# Deceased:	Cause of death:

HOSPITAL ADMISSIONS (Not including pregnancies)

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

HEALTH HABITS AND OCCUPATIONAL HAZARDS

<p>HEALTH HABITS: Check (√) which substances you use/have used and describe how much you use.</p> <p>Drugs _____ Year quit: _____</p> <p>Tobacco _____ Year quit: _____</p> <p>Alcohol _____</p> <p>Caffeine _____</p> <p>Soft drinks _____</p>	<p>Do you eat organic foods?</p> <p>Always</p> <p>Often</p> <p>Sometimes</p> <p>Never</p>	<p>Are you sensitive to:</p> <p>Sugar</p> <p>Caffeine</p> <p>Chemicals</p> <p>Perfumes</p> <p>Medicines</p>	<p>OCCUPATIONAL: Does your work expose you to the following:</p> <p>Stress</p> <p>Heavy Lifting</p> <p>Hazardous Substances</p> <p>Other: _____</p>
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What foods (if any) do you exclude from your diet? _____

Additional Comments: _____

MEDICATIONS

MEDICATIONS	DOSAGES	MEDICATIONS	DOSAGES
VITAMINS & SUPPLEMENTS	DOSAGES	VITAMINS & SUPPLEMENTS	DOSAGES

ALLERGIES TO MEDICATIONS (please list)
 No known allergies

MEDICAL HISTORY Mark C for current problems and P for past problems

Check (✓) symptoms you currently have or have had in the past year.

<u>GENERAL</u>	<u>GASTROINTESTINAL</u>	<u>EYE, EAR, NOSE, THROAT</u>	<u>MEN ONLY</u>
Anxiety	Appetite poor	Bleeding gums	Erection difficulties
Depression	Bloating	Blurred vision	Lump in testicles
Dizziness/Fainting	Bowel changes	Crossed eyes	Penis discharge
Fever	Constipation	Difficulty swallowing	Sore on penis
Forgetfulness	Diarrhea	Double vision	Other
Headache	Excessive thirst	Earache/Ear discharge	<u>WOMEN ONLY</u>
Loss of sleep	Gas	Hay fever	Abnormal vag bleeding
Loss of weight	Hemorrhoids	Hoarseness	Breast lump or pain
Numbness	Indigestion	Loss of hearing	Breast discharge
Sweats	Nausea	Nosebleeds	Extreme menstrual pain
<u>MUSCLE/JOINT/BONE</u>	Rectal bleeding	Persistent cough	Hot flashes
Pain, weakness, numbness in:	Stomach pain	Ringling in ears	Painful intercourse
Arms Hips	Vomiting	Sinus problems	Vaginal discharge
Back Legs	Vomiting blood	Vision - flashes/halos/other	Menstrual flow irregular
Feet Neck	<u>CARDIOVASCULAR</u>	<u>SKIN</u>	Miscarriages -
Hands Shoulders	Chest pain	Bruise easily	# _____
<u>GENITO-URINARY</u>	High/Low blood pressure	Hives	Last Pap Smear _____
Blood in urine	Irregular/rapid heart beat	Itching/Rash	Normal Abnormal
Frequent urination	Poor circulation	Change in moles	First day of last menstrual
Lack of bladder control	Swelling of ankles	Scars	period _____
Painful urination	Varicose veins	Sores that will not heal	Last Mammogram _____
			Normal Abnormal

Check (✓) conditions you have or have had in the past:

AIDS	Cataracts	Heart Disease	Measles	Prostate Problem
Appendicitis	Chemical Dependency	Hepatitis	Migraine Headaches	Rheumatic Fever
Arthritis	Chicken Pox	Herpes	Multiple Sclerosis	Scarlet Fever
Asthma	Diabetes	High Cholesterol	Mumps	Stroke
Bleeding Disorder	Emphysema	HIV Positive	Pacemaker	Thyroid problems
Breast Lump	Epilepsy	Kidney disease	Pneumonia	Tuberculosis
Cancer	Glaucoma	Liver Disease	Polio	Ulcers

Additional Comments:

I certify that the above information is correct to the best of my knowledge. I will not hold my provider or any members of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient or parent if minor X _____

Date X _____