

Natural Health Partners

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PATIENT HISTORY

Name: _____ D.O.B. _____ Age: _____

Present Health Concerns (in order of importance):

1. _____
2. _____
3. _____

Duration:

MEDICAL/HEALTH HISTORY:

Current Health Provider(s):

Phone:

() _____
() _____

Reason for seeing:

Date of last full physical exam: _____

Results: normal other (_____)

Date of last labwork and urine test: _____

Results: normal other (_____)

Date of last prostate exam (males): _____

Results: normal other (_____)

Date of last PAP and pelvic exam (females): _____

Results: normal other (_____)

Date of last mammogram (females): _____

Results: _____

Date of last DEXA or bone imaging (females): _____

Results: _____

For all questions – answer fully and use the space at the bottom of this form if needed.

Surgeries with Dates: _____

Hospitalizations with Dates: _____

Illnesses with Dates: _____

Injuries with Dates: _____

Allergies (drugs, food, environmental): _____

Please circle any, if life-threatening: _____

Prescription Drugs (include dosage): _____

Supplements: _____

Previous Holistic Treatments: _____

MEDICAL/FAMILY HISTORY: Add others below the boxes if not listed here and you feel they are important.

Condition	Self/Family Member
Allergies	
Alcoholism	
Anemia	
Rheumatoid Arthritis	
Osteoarthritis	
Diabetes	
Cancer ()	
High Cholesterol	
Epilepsy	
Heart disease	

Condition	Self/Family Member
Kidney disease	
Mental disorder	
Obesity	
Stroke	
Thyroid (low/high)	
Osteoporosis	
Fractures (Mom/Grandma)	
Autoimmune Disease	
Bleeding Tendency	
High Blood Pressure	

SOCIAL HISTORY

Personal Habits (Please List Current or Past Use, Frequency, and Quantity):

Tobacco: _____ Caffeine: _____ Alcohol: _____ Recreational Drugs: _____

EXERCISE: List Type of Activities: _____ Frequency per week: _____

Diet History (include any liquids, tea, coffee, etc.):

Breakfast yesterday: _____ AM Snack foods: _____
 Lunch yesterday: _____ PM Snack foods: _____
 Dinner yesterday: _____ Late PM Snack foods: _____
 Bars/Shakes: _____ Glasses or Ounces of plain water intake/day: _____
 Please List Any Dietary Restrictions: _____

What level of change to your living habits are you willing to make to improve your overall well-being?

- Whatever It Takes Significant Change Some Change No Change

REVIEW OF SYSTEMS (check if you now have or circle if you previously have had any of the following):

Hematologic:

- Anemia
- Blood diseases
- Fatigue
- Dizziness
- Excessive bleeding
- Abnormal bruising
- Blood clots

Skin/Nails:

- Skin rash/hives
- Brittle nails

HEENT:

- Headaches
- Hearing loss
- Ringing in the ears
- Vision loss/changes
- Eye pain/Itchy eyes

Gastrointestinal:

- Bad breath
- Ulcers
- Constipation
- Heartburn
- Stomach Ulcers
- Diarrhea
- Nausea
- Vomiting
- Rectal itching
- Hemorrhoids
- Hepatitis/Jaundice
- Bitter taste in mouth
- Burping
- Gas
- Cramping
- Bloating

Cardiovascular:

- Stroke
- Nosebleeds
- Varicose veins
- High/Low blood pressure
- Chest pain
- Heart Disease
- Irregular heart beat
- Swelling/edema
- Cold hands/feet
- Varicose veins

Neuro-psychiatric:

- Tingling
- Weakness
- Numbness
- Seizures
- Paralysis

Genitourinary:

- Kidney Infection
- UTI
- Kidney Disease/Stones
- Blood in urine
- Frequent urination
- Night time urination
- Incontinence
- Testicular pain or mass
- Prostate problem
- Sexual dysfunction
- STD _____

Gynecological:

- Menopause
- Breast lump
- Breast discharge
- PMS

<input type="checkbox"/> Sore throat	<input type="checkbox"/> Laxative use	<input type="checkbox"/> Poor balance	Age period started: _____
<input type="checkbox"/> Sneezing/runny nose	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Poor memory	LMP _____
<input type="checkbox"/> Nosebleeds	Frequency of BM _____	<input type="checkbox"/> Poor concentration	Periods last _____ days
<input type="checkbox"/> Sinusitis	Color of stool _____	<input type="checkbox"/> Depression	Periods come every _____ days
<input type="checkbox"/> Jaw Pain (TMJ)	Musculoskeletal:	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Pain with periods
<input type="checkbox"/> Mouth/tongue sores	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Heavy menstrual bleeding
<input type="checkbox"/> Catch colds easily	<input type="checkbox"/> Muscular pain	Respiratory:	Number of pregnancies _____
Systemic Review:	<input type="checkbox"/> Joint Pain/stiffness	<input type="checkbox"/> Tuberculosis	Number of living children _____
<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Muscular Weakness	<input type="checkbox"/> Asthma/wheezing	Number of miscarriages _____
<input type="checkbox"/> Night sweats	Endocrine:	<input type="checkbox"/> Difficulty breathing	Number of abortions _____
<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Hair loss/thinning	<input type="checkbox"/> Cough	<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal itching
<input type="checkbox"/> Chills	<input type="checkbox"/> Hormone therapy	<input type="checkbox"/> Other: _____	Currently pregnant? Yes No

Sleep: Hours/night: _____ Bedtime: _____ Waketime: _____

Do you have problems with: Difficulty remembering dreams Nightmares Staying asleep
 Waking up in the am Waking refreshed Falling asleep

Do you wake up at night? If yes, how often and at what times does this happen? _____

Energy level (average per week, circle one): (lowest energy) 1 2 3 4 5 6 7 8 9 10 (highest energy)

Stress level (average per week, circle one): (lowest stress) 1 2 3 4 5 6 7 8 9 10 (highest stress)

Sources of stress: _____ How do you cope with stress? _____

Your perspective on your health

Please use the space below to write below your thoughts on your health status. What works for you, what causes you problems, how your body reacts, etc. Also include anything you feel is important that was not asked about above.