Natural Health Partners

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PATIENT HISTORY

Name: _____ **D.O.B.** _____ **Phone #:** _____

Present Health Concerns (in order of importance): **Duration:**
1. _____ _____
2. _____ _____
3. _____ _____

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

- ☐ Sore throat
- ☐ Sneezing/runny nose
- ☐ Nosebleeds
- ☐ Sinusitis
- ☐ Jaw Pain (TMJ)
- ☐ Mouth/tongue sores
- ☐ Catch colds easily

Systemic Review:

- ☐ Hot flashes
- ☐ Night sweats
- ☐ Excessive Thirst
- ☐ Fever
- ☐ Chills
- ☐ Laxative use
- ☐ Blood in stools

Frequency of BM_____

Color of stool _____

Musculokskeletal:

- ☐ Difficulty walking
- ☐ Muscular pain
- ☐ Joint Pain/stiffness
- ☐ Muscular Weakness

Endocrine:

- ☐ Hair loss/thinning
- ☐ Dry Skin
- ☐ Hormone therapy
- ☐ Poor balance
- ☐ Poor memory
- ☐ Poor concentration
- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorder

Respiratory:

- ☐ Tuberculosis
- ☐ Asthma/wheezing
- ☐ Difficulty breathing
- ☐ Cough
- ☐ Pneumonia
- ☐ Other:_____

Age period started: _____

LMP _____

Periods last _____days

Periods come every _____days

- ☐ Pain with periods
- ☐ Heavy menstrual bleeding

Number of pregnancies _____

Number of living children _____

Number of miscarriages _____

Number of abortions _____

- ☐ Vaginal discharge
- ☐ Vaginal itching

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.