

# Natural Health Partners

South Bay Medical Bldg  
1403 Lomita Blvd., Suite 303-B  
Harbor City, CA 90710

Phone: (310) 988-8403  
Fax: (310) 634-0389  
Email: office@naturalhealthpartners.pro



## PATIENT HISTORY

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Phone #: \_\_\_\_\_

**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

**Gastrointestinal:**

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

**Cardiovascular:**

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

**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 \_\_\_\_\_

**Skin/Nails:**

- Skin rash/hives
- Brittle nails

**HEENT:**

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

**Neuro-psychiatric:**

- Tingling
- Weakness
- Numbness
- Seizures
- Paralysis

**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)	<b>Musculoskeletal:</b>	<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	<b>Respiratory:</b>	Number of pregnancies _____
<b>Systemic Review:</b>	<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	<b>Endocrine:</b>	<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.