Patient Information

Name:_____ Birth date:_____

Address:_____

Email address:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Messages regarding your healthcare may be left on: ☐ Home ☐ Cell ☐ Work ☐ None

Gender: _____ Marital status: ☐ Married ☐ Single ☐ Life Partner

Employer:_____ Occupation:_____

Emergency contact: _____ Relation: _____

Emergency contact phone: _____ Email:_____

How did you hear about us: _____

Primary care physician: _____ Phone: _____

Other health care providers: _____

Specialists: _____

Are you establishing primary care with Pacific Naturopathic: ☐Yes ☐ No

Would you like to receive our eNewsletter? ☐Yes ☐ No (We will not sell or share your email address)

Health History Questionnaire

Current health concerns:	Onset:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Current medications and doses:	Current supplements and doses:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health goals: _____

_____

Date of last physical exam:	Date of last Pap/gyne exam:	Date of last blood labs:
_____	_____	_____

Previous hospitalizations, surgeries, major accidents or illnesses (and dates): _____

_____

_____

Do you have any allergies to medications? ☐Yes ☐No If yes, please describe below.

Allergies:_____

_____

Non-drug allergies/sensitivities: _____

_____

Have you had any of the following in the past year:

☐ Chills	☐ Dizziness	☐ Fever	☐ Loss of sleep	☐ Numbness
☐ Sweats	☐ Weight change	☐ Pain	☐ Weakness	☐ Blood in urine
☐ Frequent urination	☐ Painful urination	☐ Incontinence	☐ Bloating or gas	☐ Blood in stool
☐ Constipation	☐ Diarrhea	☐ Excessive hunger	☐ Excessive thirst	☐ Hemorrhoids
☐ Indigestion	☐ Nausea	☐ Pain	☐ Poor appetite	☐ Vomiting
☐ Vomiting blood	☐ Chest pain	☐ Irregular heart beat	☐ Rapid heart beat	☐ Ankle swelling
☐ Bleeding gum	☐ Nosebleeds	☐ Ear ache	☐ Hearing loss	☐ Hoarseness
☐ Difficulty swallowing	☐ Persistent cough	☐ Ringing in ears	☐ Sinus problems	☐ Vision problems
☐ Bruising	☐ Hives	☐ Itching	☐ Mole change	☐ Rash
☐ Sores	☐ Bleeding between periods	☐ Hot flashes	☐ Nipple discharge	☐ Vaginal or penile discharge

Other symptoms not mentioned above:_____

_____

Are you fully vaccinated? ☐Yes ☐No If not, please describe which vaccinations you have had (with dates) if known. _____

_____

Menstrual and Pregnancy History

Age of first period: _____ Date of last period: _____ Cycle length: _____days

Period/bleeding length:_____days Date of last Pap: _____ ☐ Normal ☐ Abnormal

Any history of abnormal Paps: ☐ Yes ☐ No Date of last mammogram: _____

Any history of abnormal breast findings: ☐ Yes ☐ No

Do you do self-breast exams: ☐ Yes ☐ No If so, how often? _____

Number of all pregnancies: _____ Births: ☐ C-section ☐ Vaginal ☐ Vacuum ☐ Multiples

Any pregnancy complications: _____

Children's names and ages: _____

Menopausal: ☐ Yes ☐ No Current form of birth control: _____

Male Health and Prostate History

Date of last PSA: _____ PSA value: _____ Other: _____

History of Benign Prostatic Hyperplasia (BPH): ☐ Yes ☐ No

Any difficulty urinating: ☐ Yes ☐ No Please describe: _____

Do you wake at night to urinate: ☐ Yes ☐ No If yes, #/night: _____

Health Habits and Lifestyle

Do you exercise regularly: ☐ Yes ☐ No What type of exercise do you do, for how long, and how many days/week: _____

_____

Diet restrictions: ☐ None ☐ Vegetarian ☐ Vegan ☐ Other: _____

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Typical snacks: _____

Water and other fluid amount per day: _____

What is your heritage: _____ Spirituality: _____

Who lives with you: _____

How does stress affect your life: _____

Do you smoke ☐ Yes ☐ No If yes, how much: _____ Quit: ☐ Yes ☐ No ☐ Trying

Do you drink alcohol on a regular basis ☐ Yes ☐ No How much:_____

Toxic exposures: _____

How many hours of sleep/night: _____ Any sleep issues: _____

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Family History

Please check the box of any diseases that you or anyone in your family (grandparents, mother, father, siblings and children) has had and state their relation to you using the letters below:

Grandmother (GM), grandfather (GF), mother (M), father (F), siblings (S), and children (C)

☐ Allergies	☐ Anemia	☐ Alcoholism
☐ Alzheimer's	☐ Anxiety	☐ Arthritis
☐ Asthma	☐ Bipolar disorder	☐ Bleeding problems
☐ Blood pressure	☐ Cancer (type)	☐ Chronic fatigue
☐ Cholesterol	☐ Depression	☐ Diabetes (type)
☐ Digestive disorder	☐ Eating disorder	☐ Epilepsy
☐ Heart disease	☐ Hepatitis (type)	☐ HIV
☐ Kidney disease	☐ Lupus	☐ Mental illness
☐ Multiple sclerosis	☐ Neurological disorder	☐ Osteoporosis
☐ Stroke	☐ Thyroid problem	☐ Tuberculosis

Other: _____

_____

_____