



PATIENT INFORMATION FORM

Date of initial visit:		
PATIENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Street Address:		City:
Postal Code:	Home phone number:	Daytime phone number:
May we leave messages relating to your visits: <input type="checkbox"/> Yes <input type="checkbox"/> No		Email:
Date of Birth: (MM/DD/YYYY)	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	
EMERGENCY CONTACT INFORMATION		
1. Last Name:	First Name:	Relationship:
Daytime phone number:		Evening phone number:
2. Last Name:	First Name:	Relationship:
Daytime phone number:		Evening phone number:
OTHER HEALTH CARE PROVIDERS		
1. Name:	2. Name:	3. Name:
Phone number:	Phone number:	Phone number:
Specialty/focus:	Specialty/focus:	Specialty/focus:
Date of last visit to medical doctor:		Please list regular screening tests done by other physicians (blood tests, physical screening tests):
Are you currently under his/her care? <input type="checkbox"/> Yes <input type="checkbox"/> N		



Health concerns in order of importance to you:

1.

2.

3.

4.

5.

6.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date of last physical exam:

Have you been to a Naturopathic Doctor before?

Yes No

Immunizations:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Smallpox | <input type="checkbox"/> DPT (diphtheria, polio, tetanus) |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Influenza (flu shot) | <input type="checkbox"/> MMR (measles, mumps, rubella) |

List if any of these caused adverse reactions:

Childhood illnesses:

- Measles Mumps Rubella Chickenpox Rheumatic Fever Polio



List any medical conditions that other doctors have diagnosed:

1.
2.
3.
4.
5.

Surgeries:

Year	Type of Surgery	Reason

Other Hospitalizations:

Year	Reason

List your prescribed drugs, over-the-counter medications and supplements, (pain killers, vitamins, herbs, homeopathics, etc...)

Medication	Dosage/day	Date started



Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list all allergies (medications, foods, supplements, environmental, etc...)	
Name of allergen:	Reaction you had:

HEALTH HABITS AND PERSONAL SAFETY	
Exercise	<input type="checkbox"/> Sedentary (No exercise)
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation at least 3x/week for 30 minutes)
Diet	Are you dieting? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet? <input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?
	Dietary restrictions? (Religious, vegetarian, vegan?)
	Rank salt intake <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
	Rank fat intake <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
	Rank carbohydrate intake <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# of cups/cans per day?

Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per week?
Tobacco	Are you exposed to second hand smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day <input type="checkbox"/> Other (add amount)
	<input type="checkbox"/> # of years <input type="checkbox"/> Or year quit



Drugs	Do you currently use recreational drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Sex	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No				
	If yes, are you trying for a pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No				
	If not trying for a pregnancy list contraceptive or barrier method used:						
	Any discomfort with intercourse?		<input type="checkbox"/> Yes <input type="checkbox"/> No				
FAMILY HEALTH HISTORY							
INCLUDING: ALLERGIES, ASTHMA, HEART DISEASE, HIGH BLOOD PRESSURE, CANCER, DIABETES, DEPRESSION, OTHER MENTAL ILLNESS, DRUG ABUSE, ALCOHOLISM, KIDNEY DISEASE AND ANY OTHER RELEVANT HEALTH PROBLEMS.							
	AGE	SIGNIFICANT HEALTH PROBLEMS			AGE	SIGNIFICANT HEALTH PROBLEMS	
FATHER				CHILDREN		<input type="checkbox"/> M	
MOTHER						<input type="checkbox"/> F	
SIBLINGS		<input type="checkbox"/> M				<input type="checkbox"/> M	
		<input type="checkbox"/> F				<input type="checkbox"/> F	
		<input type="checkbox"/> M				<input type="checkbox"/> M	
		<input type="checkbox"/> F				<input type="checkbox"/> F	
		<input type="checkbox"/> M			<input type="checkbox"/> M		
		<input type="checkbox"/> F			<input type="checkbox"/> F		
GRANDMOTHER (maternal)				GRANDMOTHER (paternal)			
GRANDFATHER (maternal)				GRANDFATHER (paternal)			
<input type="checkbox"/> I don't know my family history							

NOTES:

Please indicate anything else that you feel is important and relevant to you and your health.
Thank you for taking the time to fill this form out.