

Naturopathic Family Medicine

Name:

DOB:

Health History

Check the following conditions that apply to you, past and present. Feel free to add your comments to clarify the condition. Please add anything else you think I should know in the additional space.

Musculo-skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain
- Tendonitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: _____

Circulatory and Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Coughing
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: _____

Skin

- Rashes
- Athlete's foot
- Warts

- Moles
- Acne
- Cosmetic surgery
- Slow wound healing
- Easy bruising
- Other: _____

Digestive:

- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's disease
- Colitis
- Rectal itching
- Date of last colonoscopy? _____
- Other: _____

Nervous System:

- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral palsy
- Epilepsy
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Other: _____

Reproductive System Women

- Pregnancy: current or previous (circle)
- PMS
- Hot flashes
- Difficulty sleeping
- Vaginal dryness

- Vaginal pain or itching
- Vaginal odor
- Difficult urination
- Pain with intercourse
- Are you sexually active? Yes / No
- Date of last menstrual period _____
- Date of last pap smear and breast exam _____

Reproductive System Men:

- Difficult urination
- Blood in urine
- Discharge from penis
- Pressure in pelvic region
- Are you sexually active? Yes / No
- Difficulty gaining or maintaining erection
- Date of last prostate exam _____

Other:

- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Anxiety
- Difficulty concentrating
- Drug use _____
- Alcohol use _____
- Nicotine use _____
- Caffeine use _____
- Hearing impaired
- Visually impaired
- Previous cancer diagnosis
- Known infectious disease
- Surgeries/hospitalizations

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Additional Questions

Tell me a little about your daily routines:

Food – (typical)
Breakfast:

Lunch:

Dinner:

Snacks:

Desserts:

Beverages:
How many glasses of water do you drink?

What is your exercise habit?

Do you have bowel movements daily?

How many hours of sleep do you routinely get? Do you feel refreshed on waking?

Describe your moods generally:

What are your top 3 health complaints?

1) _____

2) _____

3) _____
