

### ***Patient Health History Questionnaire***

*Naturopathic healthcare is possible only when the doctor completely understands the patient's physical, mental and emotional condition. The information you provide helps Dr. Thomson understand your needs and how to reach your health goals. Please answer all questions as completely as possible, and mark anything that you have a question about. And, welcome!*

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#### **PATIENT INFORMATION**

FULL NAME \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX M F  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE: HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_  
E-MAIL ADDRESS \_\_\_\_\_  
RELATIONSHIP STATUS married/single/live with partner/divorced/separated/widowed  
# CHILDREN \_\_\_\_\_ AGE(S) \_\_\_\_\_ GENDER(S) \_\_\_\_\_  
EMERGENCY CONTACT: Name \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship \_\_\_\_\_  
CURRENT OCCUPATION \_\_\_\_\_  
CURRENT EMPLOYER \_\_\_\_\_  
PREVIOUS OCCUPATION(S) \_\_\_\_\_

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How did you hear about the clinic?

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What are your most important health concerns in order of priority?

- 1.
- 2.
- 3.

What other healthcare professionals are you under the care of and why?

Name of Healthcare Provider	Type of Provider	Condition(s) Seen For
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_____	_____	_____
_____	_____	_____
_____	_____	_____

List any previous hospitalizations or surgeries

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List any medications (prescription or over-the-counter), vitamins, or natural supplements you are currently taking:

Medication or Supplement	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any allergies you have, including environmental, food, or medication \_\_\_\_\_

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## MEDICAL HISTORY

Please check any of the following that apply, and note when they started or were diagnosed:

	AIDS/HIV Infection		Frequent Antibiotic Use		Mumps
	Allergies		Frequent Steroid Use		Nervous Breakdown
	Anemia		Gallbladder Disease		Neurological Disorder
	Appendicitis		German Measles (Rubella)		Polio
	Arthritis		Giardia/ Intestinal Parasites		Prostatitis or Enlarged Prostate
	Asthma		Glaucoma		Psoriasis
	Attempted Suicide		Gout		Rheumatic Fever
	Bursitis		Hayfever		Scarlet Fever
	Cancer		Heart Disease		Seizure Disorder
	Carpal Tunnel Syndrome		Hepatitis		Sexually Transmitted Infection
	Cataracts		Herpes/Cold Sores		(chlamydia, warts, herpes, gonorrhea, syphilis)
	Chickenpox		High Blood Pressure		Sleep Apnea
	Chronic Fatigue Syndrome		Hives		Stroke/ Blood Clot
	Chronic Ear Infections		Hyper- or Hypothyroid		Substance Abuse/ Addiction
	Colitis/ Crohn's Disease		Hypoglycemia		Thrombophlebitis
	Depression		Jaundice		Toxic Exposure
	Diabetes		Kidney Infection		Vaccine Reaction
	Eating Disorder		Liver Disease		Whooping Cough (Pertussis)
	Eczema		Low Blood Pressure		Other _____
	Edema (Fluid Retention)		Measles		
	Emphysema		Migraine Headaches		
	Fibromyalgia		Mononucleosis		

## REVIEW OF SYSTEMS

Please indicate the following: Y = current condition P = past condition

### SKIN

Dry	Y P	Eczema	Y P
Oily	Y P	Color Changes	Y P
Itching	Y P	Lumps	Y P
Rashes	Y P	Fungal Infections	Y P
Bumpy/Rough	Y P	Night Sweats l.	Y P
Acne/ Boils	Y P	Warts	Y P
Hives	Y P	Other	Y P

**HEAD**

Headaches	Y P	Seizures	Y P
Location of pain		Fainting	Y P
Migraines	Y P	Dizziness	Y P
Head Injury	Y P	Other	Y P

**EYES**

Impaired Vision	Y P	Styes	Y P
Glasses/ Contacts	Y P	Infections	Y P
Pain	Y P	Sensitive to Light	Y P
Tearing/ Dryness	Y P	Other	Y P
Double Vision	Y P		

**EARS**

Impaired Hearing	Y P	Ringing	Y P
Discharge	Y P	Frequent Infections	Y P
Itching	Y P	Other	Y P
Pain	Y P		

**NOSE**

Frequent Colds	Y P	Sinus Problems/ Infections	Y P
Seasonal Allergies	Y P	Stuffiness	Y P
Chronic Discharge	Y P	Frequent Sneezing	Y P
Nose Bleeds	Y P	Other	Y P

**THROAT AND NECK**

Throat Pain	Y P	Neck Pain or Stiffness	Y P
Enlarged Glands	Y P	Clear throat Often	Y P
Difficulty Swallowing	Y P	Goiter/ Enlarged Thyroid	Y P
Hoarseness	Y P	Other	Y P

**MOUTH**

Dryness	Y P	Tongue Pain	Y P
Dental Cavities	Y P	Canker Sores	Y P
Gum Problems	Y P	Other	Y P

**RESPIRATORY**

Cough	Y P	Emphysema	Y P
Wheezing	Y P	Coughing up Blood	Y P
Pneumonia	Y P	Shortness of Breath	Y P
Chest Pain with Breathing	Y P	Other	Y P

**CARDIOVASCULAR**

Chest Pain	Y P	Varicose Veins	Y P
Heart Palpitations/ Racing	Y P	Deep Leg Pain	Y P
		Cramping	
Murmur	Y P	Foot/ Ankle Swelling	Y P
Heart Disease	Y P	Cold Hands or Feet	Y P
High or Low Blood Pressure	Y P	High Cholesterol	Y P
Angina	Y P	Other	

**GASTROINTESTINAL**

Abdominal Pain or Cramping	Y P	Mucus in Stool	Y P
Ulcer	Y P	Blood in Stool	Y P
Nausea or Vomiting	Y P	Diarrhea	Y P
Belching/ Passing Gas	Y P	Constipation	Y P
Change in Appetite	Y P	Bowel Movements: How often?	
Change in Thirst	Y P	Hemorrhoids	Y P
Heartburn	Y P	Fissures/ Fistulas	Y P
Stool Incontinence	Y P	Other	Y P
Candidiasis	Y P		

**URINARY**

Difficult Urination	Y P	Blood in Urine	Y P
Painful Urination	Y P	Bladder Infections	Y P
Incontinence/ Dribbling	Y P	Kidney Stones	Y P
Frequent Urination	Y P	Other	Y P

**FEMALE REPRODUCTIVE**

Age Menses Began		Difficulty Conceiving	Y P
Painful Menses	Y P	Are you sexually active?	Y P
Average # of days		Sexually Active With	Men Women Both
Bleeding Between Periods	Y P	Type of Birth Control	
Excessive Flow	Y P	Type of Sexually Transmitted Infection Protection	
Irregular Cycles	Y P	PMS	Y P
# Pregnancies		Breast Pain	Y P
# Births		Sexual Difficulties	Y P
# Miscarriages		Pain With Intercourse	Y P
# Abortions		Date of Last Pap Smear	
Birth Control	Y P	Abnormal Pap Result	Y P
Vaginal Yeast Infections	Y P	Date of Last Mammogram	
Endometriosis	Y P	Sexual Abuse	Y P
Pelvic Inflammatory Disease	Y P	Fibroids/ Ovarian Cysts	Y P
Hot Flashes	Y P	Other	Y P

**MALE REPRODUCTIVE**

Hernia	Y P	Change in Sex Drive	Y P
Are you sexually active?	Y P	Sexual difficulty	Y P
Sexually Active With	Men Women Both	Sexual abuse	Y P
Prostate Enlargement	Y P	Impaired Fertility	Y P

Prostate Disease	Y P	Type of Birth Control	
Change in Force of Urine Stream	Y P	Type of Sexually Transmitted Infection Protection	
Change in Urinary Frequency	Y P	Discharge from Penis	Y P
Pain or Lump in Scrotum or Testicle	Y P	Other	Y P

**MUSCULOSKELETAL**

Back Pain	Y P	Muscle Weakness	Y P
Joint Pain	Y P	Muscle Pain or Cramping	Y P
Stiff Joints	Y P	Numbness or Tingling	Y P
Bone Fracture	Y P	Osteoporosis or Osteopenia	Y P
Sprain/ Strain	Y P	Other	Y P

**NEUROLOGICAL**

Loss of Memory	Y P	Shooting Pains	Y P
Paralysis	Y P	Other	

**EMOTIONAL**

Depression	Y P	Tension	Y P
Mood Swings	Y P	Other	Y P
Anxiety or Nervousness	Y P		

**GENERAL**

Sleep # of hours/ night		Sensitive to	Hot Cold
Insomnia	Y P	Prefer weather	Humid Dry
Awaken refreshed?		Best Season: Worst Season:	
Snoring	Y P	Top Food Cravings	1.
Grind Teeth	Y P		2.
Nightmares	Y P		3.

Sleepwalking/ Talking	Y P	Excessive Thirst	Y P
Weight Change	Y P	Prefer liquids to be	Hot Cold Tepid
Alcohol Use	Y P	Have a spiritual practice?	Y P
Tobacco Use	Y P	Follow a special diet?	Y P
Recreational Drug Use	Y P	Type?	
Exercise	Y P	Fatigue	Y P
Type? How often?		Other	Y P
Current height	ft in		
Current weight	lbs		

### **FAMILY HISTORY**

Please circle any of the following conditions which have affected your family members (grandparents, parents, siblings, children):

Alcoholism	Diabetes	Kidney Disease
Drug Addiction	Eczema	Learning Disability
Allergies/ Hayfever	Epilepsy	Osteoporosis
Alzheimer's	Gallbladder Disease	Mental Illness
Anemia	Glaucoma	Mental Retardation
Arthritis	Headaches	Stroke
Asthma	Heart Attack	Suicide
Birth Defects/	Heart Disease	Thyroid Disease
Genetic disorders	Hepatitis or Liver Disease	Tuberculosis
Cancer - Type?	High Blood Pressure	Other
Depression	High Cholesterol	

Completed by \_\_\_\_\_ Date \_\_\_\_\_