Natura Medica
The Center For Natural Medicine
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PATIENT INFORMATION

DATE ________________ MARITAL

NAME____BIRTHDATE____________AGE_____SEX: M F STATUS ___

ADDRESS____
STREET CITY STATE ZIP

PH #'s (√ preferred # to use)☐HOME _________________ ☐WORK _______________ ☐CELL _________________

OCCUPATION _______________________ EMPLOYER______________________EMAIL________________________

IF RETIRED PREVIOUS OCCUPATION ____

EMERGENCY CONTACT ____
NAME RELATION

____
ADDRESS PHONE

HOW DID YOU HEAR ABOUT US? ____

LIST DOCTORS YOU ARE CURRENTLY SEEING____

____

(Note: Payment for services and pharmacy are expected at time of service)

PLEASE LIST YOUR HEALTH CONCERNS

1.____ 4.____

2.____ 5.____

3.____ 6.____

PLEASE LIST YOUR CURRENT PRESCRIPTION MEDICATIONS (INCLUDE DOSAGE)

1.____ 5.____

2.____ 6.____

3.____ 7.____

4.____ 8.____

PLEASE LIST ALL SUPPLEMENTS YOU ARE TAKING (INCLUDE DOSAGE)

1.____ 6.____

2.____ 7.____

3.____ 8.____

4.____ 9.____

5.____ 10.____

MEDICAL HISTORY

Have you ever had any of the followIng? If so, please check(/), indicate approximate date of onset and elaborate below if necessary

____AIDS or HIV Infection
____Allergies
____Anemia
____Appendicitis
____Arthritis
____Asthma
____Attempted Suicide
____Bone or Joint Disease
____Cancer
____Chronic Back Problems
____Chronic Bladder Infections
____Chronic Ear Infections
____Chronic Sinus Infections
____Chronic Vaginitis
____Chronic Bowel Problems / Colitis
____Depression
____Diabetes
____Eating Disorder
____Eczema
____Edema (Fluid Retention)
____Emphysema
____Frequent Antibiotic Use

____Frequent Steroid Use (prednisone, etc.)
____Gall Bladder Disease
____Glaucoma
____Gout
____Hay Fever
____Head Injury
____Heart Disease
____Heart Murmur
____Hepatitis
____High Blood Pressure
____High Cholesterol/Triglycerides
____Hives
____Hypoglycemia
____Hysterectomy
____Kidney Infections
____Kidney Stones
____Liver Disease
____Lyme Disease
____Migraine Headaches
____Mononucleosis
____Nervous Breakdown

____Neurological Disorder
____Occupational Exposure to Toxic Substances
____Parasites
____Phlebitis
____Polio
____Prostatitis
____Psoriasis
____Rheumatic Fever
____Seizure Disorder
____Sexually Transmitted Diseases (chlamydia, warts, herpes, gonorrhea, syphilis)
____Stroke
____Substance Abuse / Addiction
____Thyroid Disease
____TIA's (mini-strokes)
____Tuberculosis
____Ulcers

Other:____

____

____

Hospitalization (date and type of illness / procedure):

1.____

2.____

3.____

Allergies to drugs, food, other substances (please describe):

____

____

____

FAMILY HISTORY

Please indicate M-Mother, F-Father, S-Sibling, G-Grandparents, C-Children, O-Other, if family members have ever had the following:

________Blood Disorders
________Alcoholism / Drug Abuse
________ Eczema
________ Alzheimer's Disease
________ Asthma

Cancer:
________ Colon
________ Breast
________ Lung
________ Skin
________ Prostate
Other:__________________

________ Diabetes
________ Glaucoma
________ Heart Attack
________ High Blood Pressure
________ High Cholesterol
________ Mental Illness
________ Osteoporosis

________ Parkinson's Disease
________ Stroke
________ Suicide
________ Thyroid Disorder
________ Tuberculosis (TB)
Other:____________________
____

24 HOUR DIET RECALL

Breakfast	Lunch	Dinner
Snack	Snack	Snack

REVIEW OF SYSTEMS

Do you experience any of the following:

Skin

Dry _____ Oily _____
Itching _____
Rashes _____
Hives _____
Flushes Easily _____
Fungal Infections _____
Bruises Easily _____
Warts _____ Moles _____
Where ___________________________
Hair Loss _____
Nails: Soft_____ Breaks _____
Do you bite your nails? Yes___ No___

Head

Migraines _____ Headaches _____
Location of pain __________________
Worse: Light____Noise____Odors____
Seizures _____
Dizziness/Vertigo_____
Fainting _____

Eyes

Vision Disturbances _____
Dryness _____ Tearing _____
Pain _____
Styes _____
Infections _____
Sensitive to light _____

Ears

Discharge _____
Pain _____ Itch _____
Impaired Hearing _____
Ringing _____
Nose
Seasonal Allergies _____
Post Nasal Drip _____
Clears Throat Often _____
Stuffiness _____
Sinus Infections _____
Nosebleeds _____

Mouth

Dryness_____ Salivation _____
Tongue: Sore _____ Coated _____
Canker Sores _____
Fever Blisters/Cold Sores _____

Throat/Neck

Pain in Throat _____
Glands Enlarged_____
Difficult Swallowing _____
Change in Voice _____

Respiratory

Frequent Colds and Infections _____
Cough _____
Spit up Blood _____ Mucous _____
Wheezing _____
Shortness of Breath _____

Cardiovascular

Chest Pain _____
Heart Palpitations / Racing _____
Varicose Veins _____
Leg Pains _____ Cramps _____
Ankle Swelling _____
Cold Hands _____ Feet _____

Digestion

How often do you have heartburn/reflux?
____

How often do you feel gassy or bloated?
____

How often do you have a bowel movement?
____

Is it ever painful, difficult, or extremely urgent?
____

Is there undigested food in your stools?
____

Please list any foods that cause you digestive discomfort:

1._____________ 2. _____________

3. _____________ 4. _____________

Please list your symptoms after you eat these foods:

1._____________ 2. _____________

3. _____________ 4. _____________

Urinary

Difficult Urination _____
Painful Urination _____
Incontinence / Dribbling _____
Blood in Urine _____
Frequent Urination Day_____
Night_____
Bedwetting _____

General

(please circle the most accurate answer)
What is your level of energy, from 1 to 10? (10 being optimal) _______
Does it change throughout the day? ____
When?_________________________
Is it better or worse from exercise? ____
Do you tend to feel: hot /warm / neutral / cool / cold?
Are you sensitive to: heat/ cold / both?
Do you perspire easily? Yes / No
With exertion? Yes / No
During the night? Yes / No
Appetite: High / Low /Average
Thirst: High / Low / Average
For: Hot / Cold / Room Temp
Have you experienced recent change in:
Appetite ____Thirst ____ Weight _____

Lifestyle Factors: Indicate <u>Amounts</u>

Exercise_________________________
Drink Coffee ______________________
Alcohol ___________________
Soda/Diet Soda ______________
Use Tobacco ______________________
Recreational Drugs______________
IV Drugs ______________________

Women Only

Date of Last Complete Physical Exam _____
Date of Last Pelvic Exam _____
Date / Results of Last Pelvic Exam _____
Ever have an Abnormal Pap Smear? _____
DES Exposure _____
History of Sexual Abuse _____
Frequent Yeast Infections _____
Vaginal Discharge _____
Age Period Began _____
Regular Periods Yes_____ No _____
Flow:
Heavy _____ Medium _____ Light _____
Days Between Periods _____
Spotting _____
Cramps _____
Clots: _____ Days of Flow
PMS? _____ Endometriosis? _____ PID? _____
Fibroids _____
Date of Last Period ____________
Ever used Birth Control Pills? _____
How Long Ago? _______________
Present Birth Control _____
Change in Sex Drive _____
Painful Intercourse _____
Pregnancies # _____
Childbirth # _____
Age / Gender ________________________________
Complications _____
Miscarriage # _____
Abortion # _____
Impaired Fertility _____
Have You Had a Hysterectomy? _____
Age at Menopause _____
Vaginal Dryness _____
Hot Flashes _____
Breasts:
Lumps _____ Cysts _____
Discharge _____ Pain _____
Have you had sex with:
Men _____ Women _____ Both _____

Men Only

Date of Last Complete Physical Exam _____
Date of last Prostate Exam _____
Last PSA TEST _____
Prostate Enlargement _____
Change in Force of Urine Stream _____
Difficulty Starting Urine Stream _____
Do you do Self Testicular Exam? _____
Pain / Lump in Scrotum _____
Discharge From Penis _____
Difficulty with Erections _____
Change in Sex Drive _____
Children # _____
Age / Gender ________________________________
Impaired Fertility _____
DES Exposure _____
History of Sexual Abuse _____
Have you had sex with:
Women _____ Men _____ Both _____

Sleep

Difficulty falling to sleep _____
Frequent waking _____
Time: 12-1am ____ 1-2am _____ 3-4am _____4-5am _____
Nightmares _____
Restlessness _____
Sleep Position Prefers ______________________________
Wake refreshed? Yes _____ No _____
Feet Hot _____ Cold _____ in bed
Stick feet out of covers? Yes _____ No _____
Wear socks to bed? Yes _____ No _____

Muscular/Skeletal

Back Pain _____
Pain in Muscles / Joints / Bones _____
Stiffness / Swelling _____
Muscle Weakness / Tremor _____
Numbness / Tingling _____
Shooting Pain _____
Spasms _____ Twitches _____
Paralysis
Any side worse: R _____ L _____
Please list areas of pain / discomfort and describe below:
____
____
____
____

Mental/Emotional

Please list adjectives that best describe you:
1.____________ 2. ______________ 3. _____________
4. ____________________ 5. _______________________
Please mark emotions often felt:
Joy ____ Anger ____Fear ____Anxiety ____ Sadness____
Do you experience mood swings? Yes _____ No _____
Have you ever lost a loved one? Yes _____ No _____
Please describe ___________________________________
Do you cry easily? Yes _____ No _____
Do you like consolation? Yes _____ No _____

Please mark phobias:
3 = Very Strong 2 = Strong 1 = Medium
Heights ____ Bridges ____ Crowds ____ Water ____
Claustrophobia _____ Dark _____ Snakes _____
Being Alone _____ Public Speaking _____
Flying _____ Thunderstorms _____ Other _____

Any problems with:
Memory _____ Mental Clarity _____Focus/Attention Span _____

Please put a number only next to the foods you crave:
3 = Very Strong 2 = Strong 1 = Medium
Sweets_____ Chocolate _____ Salt _____ Sour _____
Hot/Spicy_____ Meats _____ Milk _____ Cheese _____
Fats_____ Eggs _____ Butter_____ Potato Chips_____
Vinegar _____ Lemons _____ Pickles _____ Coffee____
Alcohol_____ Other ____________________________

Please list any foods you dislike:
____
____
____