



## The Center For Natural Medicine

1330 SE Cesar Chavez Blvd., Portland, OR 97214 Tel: 503-232-1100; Fax: 503-232-7751

Allergies to Medications	
Name the Drug	Reaction You Had

### OTHER HEALTH ISSUES

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain. **Attach any additional information if necessary.**

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<b>Recent changes in:</b>  <input type="checkbox"/> Weight  <input type="checkbox"/> Energy level  <input type="checkbox"/> Ability to sleep  <input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	
<input type="checkbox"/> Ears	<input type="checkbox"/> Stomach/Upper Digestion	
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel/Lower Digestion	
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

### WOMEN'S HEALTH ONLY

Number of pregnancies _____	Number of live births _____	Number of miscarriages _____	Number of abortions _____
First day of last menstrual period: _____		Age at onset of menstruation: _____	
Length of your menstrual cycle (from first day of menses to the first day of your next menses): _____ Days			
Check if you have had any of the following: <input type="checkbox"/> D&C <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Oophorectomy (ovaries removed) <input type="checkbox"/> Cesarean section			
Are you: <input type="checkbox"/> Pregnant <input type="checkbox"/> Breastfeeding			
Check any of the following that you have experienced recently <b>to any significant degree</b> :			
<input type="checkbox"/> Heavy periods	<input type="checkbox"/> Irregular cycle	<input type="checkbox"/> Spotting between periods	<input type="checkbox"/> Menstrual cramps
<input type="checkbox"/> Premenstrual irritability	<input type="checkbox"/> Vaginal irritation/itching/burning	<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Breast lumps
<input type="checkbox"/> Premenstrual bloating		<input type="checkbox"/> Nipple discharge	
<input type="checkbox"/> Other symptoms: _____			
Date of last Pap smear and annual exam? _____		Date of last mammogram? _____	
Have you ever had an abnormal Pap smear result? <input type="checkbox"/> Yes <input type="checkbox"/> No    When? _____		Have you had a positive HPV test? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any urinary tract, bladder, or kidney infections within the last year?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems with control of urination?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any hot flashes or sweating at night?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have any discomfort with intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you are sexually active, are you trying for a pregnancy?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If not trying for a pregnancy, list whatever method of contraception you use:			

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### MEN'S HEALTH ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any testicle pain, lumps, or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam? _____	Date of last PSA blood test (prostate cancer screening)? _____	

### HEALTH HABITS

<b>Exercise</b>	Do you exercise regularly?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How often and for how long?				
	What do you do for exercise?				
<b>Height and Weight</b>	Height: _____	Weight: _____			
	Weight 1 year ago: _____				
	Maximum weight: _____	When were you at your maximum weight?: _____			
<b>Diet:</b> <i>List all food consumed in the past 24 hours</i>	Breakfast: _____				
	Lunch: _____				
	Dinner: _____				
	Snacks: _____				
	Beverages (including water): _____				
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day? _____				
<b>Alcohol</b>	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How many drinks per week? _____				
<b>Tobacco</b>	Do you use tobacco?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day: _____	<input type="checkbox"/> Chew - #/day: _____	<input type="checkbox"/> Pipe - #/day: _____	<input type="checkbox"/> Cigars - #/day: _____	
	<input type="checkbox"/> # of years _____	<input type="checkbox"/> Or year quit: _____	If you use tobacco, are you interested in quitting? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Drugs</b>	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

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### MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						
Have you ever taken medications for depression, anxiety, or other mental health problems?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						
Do you <b>currently</b> experience any of the following: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety/Panic Disorder <input type="checkbox"/> Post-Traumatic Stress Disorder <input type="checkbox"/> Other mental health issue:										
How are things going for you at your job?	<input type="checkbox"/>	Very Well	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poorly	<input type="checkbox"/>	Very Poorly	<input type="checkbox"/>	N/A
....at school?	<input type="checkbox"/>	Very Well	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poorly	<input type="checkbox"/>	Very Poorly	<input type="checkbox"/>	N/A
....with your spouse/partner?	<input type="checkbox"/>	Very Well	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poorly	<input type="checkbox"/>	Very Poorly	<input type="checkbox"/>	N/A
....with your children?	<input type="checkbox"/>	Very Well	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poorly	<input type="checkbox"/>	Very Poorly	<input type="checkbox"/>	N/A
....with your friends/social life?	<input type="checkbox"/>	Very Well	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poorly	<input type="checkbox"/>	Very Poorly	<input type="checkbox"/>	N/A
....with your attitude/mood?	<input type="checkbox"/>	Very Well	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poorly	<input type="checkbox"/>	Very Poorly	<input type="checkbox"/>	N/A

### FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS	AGE AT DEATH	CAUSE OF DEATH
<b>Parents and Grandparents</b>				
<b>Father</b>				
<b>GrandMOTHER</b> <i>Paternal</i>				
<b>GrandFATHER</b> <i>Paternal</i>				
<b>Mother</b>				
<b>GrandMOTHER</b> <i>Maternal</i>				
<b>GrandFATHER</b> <i>Maternal</i>				
<b>Siblings</b>				
<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> M <input type="checkbox"/> F				
<b>Children</b>				
<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> M <input type="checkbox"/> F				
<input type="checkbox"/> M <input type="checkbox"/> F				

**Is there anything else you would like us to know to better serve you?**