*The Center For Natural Medicine*
**1330 SE Cesar Chavez Blvd., Portland, OR 97214 Tel: 503-232-1100; Fax: 503-232-7751**

# PATIENT HEALTH HISTORY

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

| **Name:** | **Date of birth:** | ☐ M ☐ F | **Today's Date:** |
|---|---|---|---|
| | | | |

| **WHAT IS YOUR MAIN REASON FOR COMING TO THE CLINIC TODAY?** |
|---|
| |

| **PERSONAL HEALTH HISTORY** | | |
|---|---|---|
| **List all ongoing medical problems:** | | |
| | | |
| | | |
| | | |
| **Childhood illness:** ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio | | |
| **Immunizations and dates:** | ☐ DPT/Tetanus | ☐ Pneumonia |
| | ☐ Hepatitis | ☐ Chickenpox |
| | ☐ Influenza | ☐ MMR *Measles, Mumps, Rubella* |

**Surgeries and/or Hospitalizations**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please list any imaging or diagnostic tests you have had *in the past 2 years*** (chest x-ray, EKG, colonoscopy, bone density scan, etc.)

| Year | Test | Year | Test |
|---|---|---|---|
| | | | |
| | | | |

**Do you currently see any other physicians (MD, ND, DO, DC, etc.)? Please list, and indicate your primary care doctor (if any).**

**List your prescribed drugs, over-the-counter drugs, and natural medications (vitamins, herbs, etc.). Attach additional list if needed.**

| Name the Drug | Strength | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
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| **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.**

| | | |
|---|---|---|
| ☐ Skin | ☐ Chest/Heart | ***Recent changes in:*** |
| ☐ Head/Neck | ☐ Back | ☐ Weight |
| ☐ Ears | ☐ Stomach/Upper Digestion | ☐ Energy level |
| ☐ Nose | ☐ Bladder | ☐ Ability to sleep |
| ☐ Throat | ☐ Bowel/Lower Digestion | ☐ Other pain/discomfort: |
| ☐ Lungs | ☐ 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: ☐ D&C ☐ Hysterectomy ☐ Oophorectomy (ovaries removed) ☐ Cesarean section

Are you: ☐ Pregnant ☐ Breastfeeding

Check any of the following that you have experienced recently ***to any significant degree***:

☐ Heavy periods ☐ Irregular cycle ☐ Spotting between periods ☐ Menstrual cramps ☐ Premenstrual bloating
☐ Premenstrual irritability ☐ Vaginal irritation/itching/burning ☐Breast tenderness ☐Breast lumps ☐Nipple discharge

☐ Other symptoms: _____

Date of last Pap smear and annual exam? _____ | Date of last mammogram? _____

Have you ever had an abnormal Pap smear result? ☐ Yes ☐ No When? _____ Have you had a positive HPV test? ☐ Yes ☐ No

| | | |
|---|---|---|
| Have you had any urinary tract, bladder, or kidney infections within the last year? | ☐ Yes | ☐ No |
| Do you have any problems with control of urination? | ☐ Yes | ☐ No |
| Do you have any hot flashes or sweating at night? | ☐ Yes | ☐ No |

Are you sexually active? ☐ Yes ☐ No Do you have any discomfort with intercourse? ☐ Yes ☐ No

| | | |
|---|---|---|
| If you are sexually active, are you trying for a pregnancy? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No |
| If yes, # of times _____ | | |
| Do you feel pain or burning with urination? | ☐ Yes | ☐ No |
| Do you have any difficulty with erection or ejaculation? | ☐ Yes | ☐ No |
| Has the force of your urination decreased? | ☐ Yes | ☐ No |
| Do you have any problems emptying your bladder completely? | ☐ Yes | ☐ No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | ☐ Yes | ☐ No |
| Do you have any testicle pain, lumps, or swelling? | ☐ Yes | ☐ No |
| Date of last prostate and rectal exam? _____ | Date of last PSA blood test (prostate cancer screening)? _____ | |

## HEALTH HABITS

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

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## MENTAL HEALTH

| | | |
|---|---|---|
| Is stress a major problem for you? | ☐ Yes | ☐ No |
| Have you ever taken medications for depression, anxiety, or other mental health problems? | ☐ Yes | ☐ No |

Do you **currently** experience any of the following: ☐ Depression ☐ Anxiety/Panic Disorder ☐ Post-Traumatic Stress Disorder ☐ Other mental health issue:

| | | | | | |
|---|---|---|---|---|---|
| How are things going for you at your job? | ☐ Very Well | ☐ Fair | ☐ Poorly | ☐ Very Poorly | ☐ N/A |
| ....at school? | ☐ Very Well | ☐ Fair | ☐ Poorly | ☐ Very Poorly | ☐ N/A |
| ....with your spouse/partner? | ☐ Very Well | ☐ Fair | ☐ Poorly | ☐ Very Poorly | ☐ N/A |
| ....with your children? | ☐ Very Well | ☐ Fair | ☐ Poorly | ☐ Very Poorly | ☐ N/A |
| ....with your friends/social life? | ☐ Very Well | ☐ Fair | ☐ Poorly | ☐ Very Poorly | ☐ N/A |
| ....with your attitude/mood? | ☐ Very Well | ☐ Fair | ☐ Poorly | ☐ Very Poorly | ☐ N/A |

## FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | AGE AT DEATH | CAUSE OF DEATH |
|---|---|---|---|---|
| ***Parents and Grandparents*** | | | | |
| **Father** | | | | |
| **GrandMOTHER** *Paternal* | | | | |
| **GrandFATHER** *Paternal* | | | | |
| **Mother** | | | | |
| **GrandMOTHER** *Maternal* | | | | |
| **GrandFATHER** *Maternal* | | | | |
| ***Siblings*** | | | | |
| ☐ M ☐ F | | | | |
| ☐ M ☐ F | | | | |
| ☐ M ☐ F | | | | |
| ☐ M ☐ F | | | | |
| ***Children*** | | | | |
| ☐ M ☐ F | | | | |
| ☐ M ☐ F | | | | |
| ☐ M ☐ F | | | | |
| ☐ M ☐ F | | | | |

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