Patient Information &
Confidential Medical History

Today's Date:_____Social Security #_____

Name:_____Birthdate:_____Age:_____

Home Address:_____City:_____State:_____Zip:_____

Home Telephone:_____Cell Phone:_____

E-Mail Address:_____

Occupation:_____Place of Work:_____

Emergency Contact Information: (Name & Number)_____

Name of your family doctor:_____Phone:_____

Reason for today's appointment:_____

MEDICATIONS

Please list all of the prescription medications, nutritional supplements, over the counter medicines, homeopathic remedies or other substances you are *currently* taking.

Name of medicine	Dosage	Frequency
(Example): Tylenol	**250 mg**	**once daily**

PERSONAL HISTORY & RISK FACTORS

(Please place an "X" by all that apply for you)

PAST & CURRENT MEDICAL HISTORY

- ☐ Cancer
- ☐ Heart disease
- ☐ Diabetes
- ☐ Auto-immune disease
- ☐ Arthritis
- ☐ Hepatitis
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Measles
- ☐ Mumps
- ☐ Chickenpox
- ☐ Small pox

HEAD & NECK

- ☐ Headaches
- ☐ Cataracts
- ☐ Failing vision
- ☐ Double vision
- ☐ Visual "floaters"
- ☐ Visual loss
- ☐ Glasses/contacts
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Pain in the ears
- ☐ Discharge from the ears
- ☐ Nosebleeds
- ☐ Teeth problems
- ☐ Root canals
- ☐ Sinus congestion

Runny nose

- ☐ Frequent colds
- ☐ Tongue problems
- ☐ Gum problems
- ☐ Voice problems
- ☐ Swellings in the neck
- ☐ Sinusitis

CARDIOVASCULAR

- ☐ Heart attack
- ☐ Stroke
- ☐ Angioplasty
- ☐ Heart surgery
- ☐ Atherosclerosis
- ☐ Hypertension
- ☐ Arrhythmia
- ☐ Chest pain on effort
- ☐ Swelling ankles
- ☐ Irregular heart beats
- ☐ High cholesterol
- ☐ Angina

PULMONARY

- ☐ Cough
- ☐ Wheezing
- ☐ Tuberculosis
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Pneumonia
- ☐ Valley fever
- ☐ Sit up to breath easier
- ☐ Spit up blood
- ☐ Chest colds
- ☐ Shortness of breath

SKIN

- ☐ Dryness
- ☐ Oily skin
- ☐ Itching
- ☐ Rashes
- ☐ Acne
- ☐ Discoloration
- ☐ Psoriasis
- ☐ Eczema
- ☐ Hives

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Nausea
- ☐ Heartburn
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Ulcers
- ☐ Liver problems
- ☐ Appetite loss
- ☐ Irregular bowel movements
- ☐ Days without bowel movement
- ☐ Black tarry stools
- ☐ Bloating
- ☐ Clay colored stools
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Vomiting
- ☐ Ulcers
- ☐ Gas

GENITOURINARY

- ☐ Frequent urination
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Retention of urine
- ☐ Leakage of urine
- ☐ Pain with urination
- ☐ Burning urination
- ☐ Urination during the night
- ☐ Difficulty starting urinary flow
- ☐ Dribbling after urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Bedwetting

MUSCULOSKELETAL

- ☐ Back pain
- ☐ Joint problems
- ☐ Muscle problems
- ☐ Weakness
- ☐ Disabled
- ☐ Tingling
- ☐ Numbness
- ☐ Balance problems
- ☐ Body aches & pain
- ☐ Fatigue
- ☐ Weight loss

NEUROLOGICAL/PSYCHOLOGICAL

- ☐ Depression
- ☐ Nervous breakdown
- ☐ Dizziness
- ☐ Lightheaded
- ☐ Fainting
- ☐ Paralysis
- ☐ Memory loss
- ☐ Personality changes
- ☐ Speech disturbances
- ☐ Counseling
- ☐ Alcohol problems
- ☐ Drug problems
- ☐ Epilepsy
- ☐ Seizures
- ☐ Alzheimer's
- ☐ Dementia
- ☐ Parkinson's

DIETARY

- ☐ Coffee
- ☐ Tea
- ☐ Soda
- ☐ Beer
- ☐ Wine
- ☐ Liquor
- ☐ Candy
- ☐ Fried foods
- ☐ Fast foods
- ☐ Breads
- ☐ Chips
- ☐ Margarine
- ☐ Vegetables
- ☐ Fruit
- ☐ Cakes
- ☐ Cookies
- ☐ Pies
- ☐ Beef
- ☐ Fish
- ☐ Chicken
- ☐ Turkey
- ☐ Grains
- ☐ Milk
- ☐ Cheese
- ☐ Wheat
- ☐ Corn

OB/GYN

- ☐ Menopause
- ☐ PMS
- ☐ Painful periods
- ☐ Missed periods
- ☐ Bleed between periods
- ☐ Excessive menstruation
- ☐ Cramping
- ☐ Clots
- ☐ Yeast infections
- ☐ Breast tenderness
- ☐ Breast discharge
- ☐ Breast lumps
- ☐ Birth control
- ☐ Regular PAP
- ☐ Vaginal discharge
- ☐ Been pregnant
- ☐ Abortion
- ☐ Miscarriage

Do you exercise? If yes, how often?_____

Do you consider yourself overweight? How much?_____

Do you use recreational drugs? If so, what?_____

Do you practice stress management/relaxation techniques? What kind?_____

What is your stress level? (0=none, 10=extreme) _____

Are you now or have you ever been a cigarette smoker?_____Packs a Day_____
Years Smoked_____If you quit, when?_____Do you want to quit?_____

FAMILY HISTORY

Please list ages, health problems and if deceased, cause of death

Relative	Current Age	Health Problem(s)	Age of Death	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

Please list any operations, major illnesses and hospitalizations, with approximate date:
_____
_____

Please list any known allergies or hypersensitivities you have to drugs, foods, chemicals, pollens, molds, latex, adhesive tape, etc. _____
_____

What events or experiences have transpired for you that have led to your decision to pursue Naturopathic Medical Care?_____
_____

How did you learn about us or who referred you to us?
_____

MEDICAL GOALS

List the top four goals you wish to achieve in regards to your health and general well being.

1._____

2._____

3._____

4._____

Is there any information that was not covered in this questionnaire that you feel is important to comment on? If yes, please explain_____
_____
_____

PLEASE READ AND SIGN YOUR NAME

I understand that Westhampton and Arizona Prohealth, LLC is a fee for service, cash based medical office and does not currently accept insurance coverage. I understand that I may submit the Superbill received from this office to my insurance company for financial reimbursement. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment on the day the services are rendered. Methods of payment are cash, check, Visa and Mastercard and Discover.

Please Print Your Name:_____

Please Sign Your Name:_____

Today's Date:_____