Natural Family Medicine
16701 SE McGillivray Blvd., Suite 265, Vancouver, WA 98683
Phone: 360.882.1339; Fax: 360.253.8006

HEALTH HISTORY

PATIENT NAME: _____ **BIRTHDATE:** _____ **DATE:** _____

To help us meet your healthcare needs, please fill out BOTH SIDES of this form completely. This is a confidential record of your medical history and will be kept in this office.

Chief Complaint(s): Please list your primary reason for today's appointment: _____
_____

Place of birth: _____
Occupation: _____
Previous occupation(s): _____
Marital status: _____
Exercise: _____
Alcohol (type and amount/day): _____
Caffeine (type and amount/day): _____
Water (amount/day): _____
Smoking (type and amount/day): _____
If former smoker, date quit: _____
Street drugs (type and amount/day): _____
Please list all allergies (foods, drugs, and environmental):
_____
_____
_____
Height: _____ Weight: _____
Date of last dental exam: _____
Date of last eye exam: _____

Date of last physical exam: _____
Date of last blood work:_____
Doctor: _____ Phone: _____
Please list all medicines you are currently taking: □ None
_____
_____
_____
Please list all supplements you are currently taking: □ None
_____
_____
_____
Please list all serious illnesses, operations, injuries, head injuries, fractures or broken bones, and other hospitalizations you have experienced. Include the year these occurred: □ None
_____
_____
_____
_____

Past Medical History: Have you ever had the following? Circle "no" or "yes". Leave blank if uncertain.

Measles	no	yes	Epilepsy	no	yes	Hives	no	yes
Mumps	no	yes	Migraines	no	yes	Eczema	no	yes
Chickenpox	no	yes	Tuberculosis	no	yes	AIDS or HIV +	no	yes
Whooping cough	no	yes	Diabetes	no	yes	Infectious Mono	no	yes
Scarlet fever	no	yes	Cancer	no	yes	Bronchitis	no	yes
Diphtheria	no	yes	Polio	no	yes	Stroke	no	yes
Smallpox	no	yes	Glaucoma	no	yes	Hepatitis	no	yes
Pneumonia	no	yes	Hernia	no	yes	Ulcer	no	yes
Rheumatic fever	no	yes	Blood/Plasma transfusions	no	yes	Kidney disease	no	yes
Heart disease	no	yes	Back trouble	no	yes	Thyroid disease	no	yes
Arthritis	no	yes	High blood pressure	no	yes	Bleeding tendency	no	yes
Venereal disease	no	yes	Low blood pressure	no	yes	Any other disease	no	yes
Anemia	no	yes	Hemorrhoids	no	yes	Please list: _____		
Bladder infections	no	yes	Asthma	no	yes	_____		

Vaccine History: _____
_____

Family History: Has any blood relative had any of the following? Circle "no" or "yes". Leave blank if uncertain.

Cancer	no	yes	Epilepsy	no	yes	Obesity	no	yes
Type: _____			Allergies	no	yes	Low thyroid function	no	yes
Leukemia	no	yes	Anemia	no	yes	High thyroid function	no	yes
Tuberculosis	no	yes	Bleeding tendency	no	yes	Ulcer	no	yes
Diabetes	no	yes	Asthma	no	yes	High cholesterol	no	yes
Heart disease	no	yes	Depression	no	yes	Kidney disease	no	yes
High blood pressure	no	yes	Alzheimer's	no	yes	Glaucoma	no	yes
Stroke	no	yes	Migraines	no	yes	Gout	no	yes

Please complete reverse side →

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Family History (continued):

Present age or age of death: If living, health (good, fair, poor). If deceased, cause of death:

Father: _____
Mother: _____
Siblings: _____
_____
_____
Spouse: _____
Children: _____
_____
_____

In the past one year or do you now have: Circle "no" or "yes".

Unexplained weight change. .	no	yes	Chest pain	no	yes	Itchiness	no	yes
Appetite change	no	yes	Palpitations/Heart fluttering .	no	yes	Yellow jaundice	no	yes
Fatigue	no	yes	Heart murmur	no	yes	Seizures	no	yes
Weakness	no	yes	Enlarged veins	no	yes	Memory loss	no	yes
Persistent fever	no	yes	Purple fingers or toes	no	yes	Paralysis	no	yes
Cold sensitivity	no	yes	Swelling of hands, feet, or			Clumsiness	no	yes
Heat sensitivity	no	yes	ankles	no	yes	Dizziness	no	yes
Night sweats	no	yes	Stomach pain	no	yes	Fainting	no	yes
Hot flashes	no	yes	Heartburn	no	yes	Numbness/tingling	no	yes
Recent trauma	no	yes	Frequent belching	no	yes	Depression	no	yes
Recent infection	no	yes	Nausea	no	yes	Anxiety	no	yes
Headaches	no	yes	Vomiting	no	yes	Difficult sleeping.	no	yes
Blurred vision	no	yes	Vomited or coughed up					
Double vision	no	yes	blood	no	yes	**Men only:**		
Eye pain	no	yes	Chronic diarrhea	no	yes	Discharge from penis	no	yes
Do you wear glasses or			Chronic constipation	no	yes	Pain in testicles	no	yes
contacts?	no	yes	How often do you have a BM? _____			Lump in testicles	no	yes
Ear pain	no	yes	Rectal bleeding	no	yes	Impotence	no	yes
Hearing changes	no	yes	Blood in stool	no	yes			
Ringing in ears	no	yes	Mucus in stool	no	yes	**Women only:**		
Ear discharge	no	yes	Undigested food in stool . . .	no	yes	Age period began: _____		
Frequent nosebleeds	no	yes	Dark urine	no	yes	Days periods bleed: _____		
Frequent colds	no	yes	Frequent urination	no	yes	Days between periods: _____		
Sore throat	no	yes	Increased thirst	no	yes	Date of last period: _____		
Sinus trouble	no	yes	Painful urination	no	yes	Date of last pelvic exam: _____		
Loss of smell	no	yes	Blood in urine	no	yes	Date of last mammogram: _____		
Persistent hoarseness	no	yes	Difficulty starting urine flow.	no	yes	Abnormal PAP in past	no	yes
Difficulty swallowing	no	yes	Urination during night	no	yes	Heavy flow	no	yes
Sore tongue	no	yes	Leakage of urine	no	yes	Bleed or spot between		
Sore gums	no	yes	Backaches	no	yes	periods.	no	yes
Face pain	no	yes	Leg cramps	no	yes	Pain or cramps	no	yes
Lump or discharge			Muscle cramps	no	yes	Vaginal itching	no	yes
from breast	no	yes	Joint pain or stiffness	no	yes	Pain with intercourse	no	yes
Shortness of breath	no	yes	Swollen joints	no	yes	Type of birth control used: _____		
Wheezing	no	yes	Skin rash	no	yes	Number of pregnancies: _____		
Difficulty breathing	no	yes	Hair changes	no	yes	Number of full-term births: _____		
Bloody sputum	no	yes	Nail changes	no	yes	Number of pre-term births: _____		
Chronic cough	no	yes	Easy bleeding	no	yes			
Do you sleep propped up . . .	no	yes	Easy bruising	no	yes			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

Signature of patient (or parent if minor): _____ Date: _____

Please complete reverse side →