



Naturopathic HEALTH HISTORY

Dr. Susan J. Wojcik

Name: _____ Birthdate: _____
 Date: ____ / ____ / ____ Age: _____

GENERAL

Place of birth	Education
Relationship status	Occupation
Hobbies	Previous occupations
Exercise/recreation	Height
Weight	
Date of last Physical Exam	Date of last Eye exam
Date of last colonoscopy	Date of last Prostate exam
Date of last full bloodwork	Date of last Bone Density testing
Date of last Mammogram	Date of last Dental Exam
Describe all serious accidents, severe injuries, head injury, fractures or broken abones (include date occurred): <input type="checkbox"/> None	List all serious illnesses, operations, and other operations, and other hospitalizations you have experienced and indicate year these occurred: <input type="checkbox"/> None

CHIEF COMPLAINTS: Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

MEDICATION (Include everything you have taken or are taking: pills, tablets, liquids, ointments, suppositories, etc)

Antacids	Antibiotic/Antifungal	Antidepressants	Antidiabetic/Insulin
Aspirin/Tylenol	Chemotherapy	Cortisone	Anti-Inflammatories
Heart Medications	High Blood Pressure	Hormones	Laxatives
Lithium	Oral Contraceptives	Radiation	Recreational Drugs
Relaxants/Sleeping Pills	Thyroid	Ulcer Medication	Other

VITAMINS, MINERALS, HERBS, DOSES

ALLERGIES:

Drugs:
 Foods:
 Environmental Sources:
 Other:

CIRCLE IF YOU:

Diet often	Are under excessive stress	Are exposed to chemicals at work	Do not sleep well
Eating Disorder	Recreational Drugs	Spiritual Practice, please indicate	

DO YOU DRINK OR CONSUME:

Alcohol	Candy	Carbonated beverages	Cheese
Cigarettes	Coffee	Meals at fast food restaurants	Fried foods
Luncheon meats	Margarine	Meat eater	Milk or Ice Cream
Refined sugar	Saccharine or Aspartame	Chew tobacco	Butter

DIET: *please list typical foods consumed on a regular basis*

Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____
 Fluids: _____
 Alcohol: _____

PAST MEDICAL HISTORY

Measles	no	yes	Hernia	no	yes
Hives or Eczema	no	yes	Thyroid Disease	no	yes
Mumps	no	yes	Blood Transfusions	no	yes
Tuberculosis	no	yes	Kidney Disease	no	yes
Infectious Mono	no	yes	AIDs or HIV+	no	yes
Chickenpox	no	yes	Heart Disease	no	yes
Diabetes	no	yes	Bleeding tendency	no	yes
Rheumatic Fever	no	yes	High Blood Pressure	no	yes
Whooping Cough	no	yes	High Cholesterol	no	yes
Cancer	no	yes	Anemia	no	yes
Mitral Valve Prolapse	no	yes	STD's	no	yes
Scarlet Fever	no	yes	Any other disease (please list)		
Polio	no	yes	_____		
Stroke	no	yes	_____		
Glaucoma	no	yes	_____		
Hepatitis	no	yes			
Smallpox	no	yes			

FAMILY HISTORY:

	Who		Who
Alcohol or Drug Problem		HIV	
Allergies		Kidney Disease	
Anemia		Leukemia	
Ankylosing Spondilitis		Mental Illness	
Asthma		Migraine Headaches	
Autoimmune disorders		Multiple Sclerosis	
Cancer		Muscular Dystrophy	
Chronic Lung Disease		Obesity	
Diabetes		Osteoporosis	
Eczema		Psoriasis	
Epilepsy		Rheumatoid Arthritis	
Glaucoma		Stroke	
Gout		Thyroid Disease	
Heart Disease		Tuberculosis	
Hepatitis		Ulcers	
High Blood Pressure		Other	
High Cholesterol			

REVIEW OF SYSTEMS

Please check any of the following conditions which apply to you either currently or in the past.

SKIN

Rashes
Jaundice
Dry skin
Shingles
Acne
Dry skin

Hives
Lesions (cuts take a long time to heal)
Eczema
Ringworm
Excessive perspiration
Bruising easily

Bumpy skin on back of arms
Changes in hair/ nails
Psoriasis
Athletes foot
Body odor

HEAD

Hair loss/thinning
Headache

Dry coarse hair
Migraines

Head injury

EYES

Itchy eyes
Eyes sensitive to light
Double vision
Dry eyes
Floaters

Red or inflamed eyes
Eye pain
Discharge from eyes
Styes
Lasix or correstive surgery

Impaired vision
Blurred vision
Watery eyes
Puffiness/dark circles under eyes

EARS

Impaired hearing
Wax in the ears
Itchy ears

Ringing in the ears
Ear Pain
Ear discharge or ears stuffed up

Earache
Ear infections

NOSE & SINUSES

Frequent colds
Nasal congestion
Loss of smell

Post nasal drip
Sinus problems
Itchy nose

Nose bleeds
Breathe through mouth
Allergies

MOUTH & THROAT

Frequent sore throat
Hoarseness
Inflamed/bleeding gums
Difficulty swallowing
Dry mouth

Throat infections
Sores in mouth/on lips
Dental / Gum problems
Loss of taste
Crack in corners of mouth

Mucous in throat
Dentures
Swollen tongue
Itchy mouth or throat
Chapped lips

NECK

Swollen glands

Pain or stiffness

BLOOD

Anemia

Easy bleeding

Easy bruising

RESPIRATORY

Chronic cough
Smoker
Lung congestion
Wheezing / Asthma

Coughing up blood/phlegm
Exposed to chemicals/radiation
Sensitive to smog/pollution
Positive TB test ever?

Bronchitis/Pneumonia
Live/work with people who smoke
Difficulty or pain with breathing
Shortness of breath

HEART

Heart Disease
Chest pain
Rapid beating heart
Chest tightness
Heaviness in legs
Swelling in ankles
Dizziness upon standing

High Blood pressure
Do you do aerobic exercise
Calf muscles cramp while walking
Drink >5 cups of coffee/day
Difficulty breathing at night
MVP

Low Blood pressure
Exhaustion with minor exertion
Heart Fluttering
High cholesterol
Severe cough
Heart Murmur

CIRCULATION

Deep leg pain
Purple fingers or lips

Cold hands/feet

Varicose veins

DIGESTION

Mucous in stools
Heartburn / Antacid use
Stomach upset/pain
Indigestion
Foul smelly stools
Ulcers
Change in appetite
Fatigue after eating
Floating stool

Constipation (< 1 bm/day)
4 or more BM's per day
Belching or burping
Liver/Gall Bladder disease
Hemorrhoids
Blood in stools
Black tarry stools
Food sensitivity
Feeling of incomplete bowel movement

Trouble swallowing
Intolerance to greasy foods
Loose Stools or Diarrhea
Relief of pain by drinking milk
Bad breath / Body odor
Gas, Bloating, Abdominal cramps
Nausea or Vomiting
Undigested food in stool
Hemorrhoids

URINARY

Frequent urination
Inability to hold urine
Can't hold urine
Cloudy urine
Dark urine
Bedwetting

Frequent vaginal infections
Rarely need to urinate
Painful/burning when urinating
Rose colored (bloody) urine
Kidney or bladder infections

Urination at night
Urination cough or sneeze
Dripping after urination
Strong smelling urine
Antibiotics for urinary infections

NEUROLOGIC

Fainting
Muscle weakness
Poor concentration
Loss of balance
Head feels heavy
Trembling in hands
Loss of grip strength

Seizures / Convulsions
Numbness or tingling
Ringing in ears
Dizziness or Vertigo
Headache / Migraine
Loss of feeling in hands/feet/toes

Paralysis
Loss of memory
Need for 10-12 hours sleep
Lack of mental alertness
Loss of muscle tone
Uncoordinated

IMMUNE SYSTEM

Frequent infections
Swollen lymph glands

Night sweats

Poor wound healing

ENERGY & SLEEP

Chronic fatigue
Feel tired in afternoon
Need coffee to get started

Can't fall asleep
Intense dreams or Nightmares

Restless / uneasy sleeper
Wake up middle of night

ENDOCRINE

Night sweats	Hypoglycemia	Excessive thirst
Excessive hunger	Strong smelling urine	Lowered resistance to infection
Boils and leg sores	Feel tired/weak if meal is missed	Menstrual irregularities
Overweight	Cuts take a long time to heal	Feel energized from exercise
Failing eyesight	Sugar in urine	Family history of Diabetes
Crave sweets	Dry skin	Thick skin and fingernails
Swollen eyes (bulging)	PMS or heavy bleeding	Chronic fatigue
Depressed / apathetic	Trouble waking up in morning	Low sex drive
Any thyroid problems	Heat or cold intolerance	Thinning outside of eyebrows
Gain weight easily	Temperature below 98.6	Fatigue
Course / Dry skin	Headaches relieved by eating	Infertility
Dizziness upon standing	Irritable if a meal is missed	Feel shaky or jittery
Calmer after eating	Awaken at night hungry	Heart palpitations after eating
Feel tired after eating	Impatient/moody/nervous/anxious	

MALE REPRODUCTION

Difficulty urinating	A sense of bladder fullness	Discharge from penis
Low sperm count	Pain or burning while urinating	Wake up to urinate at night
Dripping after urination	Pain/fatigue in back	Lack of sex drive
Ejaculation causes pain	Sexual difficulties	Testicular lump or pain
Premature ejaculation	Pain/coldness in genital area	Sores on penis
Infertile	Rose colored (bloody) urine	Hernias
Prostate problems	Sexually transmitted diseases	

FEMALE REPRODUCTION

Pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Date of Last Menstrual cycle ___/___/___ Days Between Cycles _____ Usual Length of cycle ___ days

Age menses began _____ Are cycles regular? _____ Date of last pap smear ___/___/___

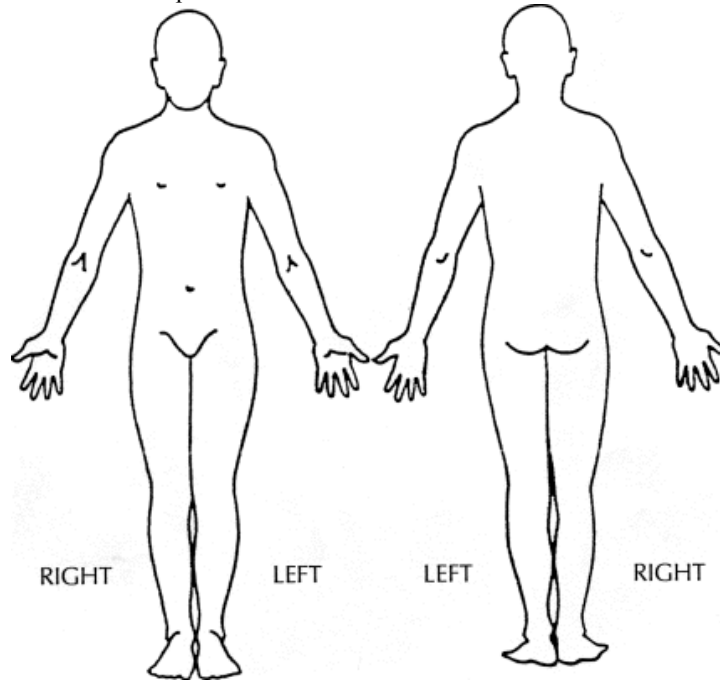
Monthly weight gain	Depression Moodiness/irritability	Bloating and swelling
Nausea and/or vomiting	Anxiety	Leg cramps and tenderness
Headaches	Suicidal feelings	Low abdominal pain/cramping
Tender Breasts	Low backache	Bleeding between periods
Pain during intercourse	Vaginal discharge	Excessive flow
Difficulty conceiving	Vaginal yeast infections	Light blood flow
Night sweats	Hot flashes	Sexually transmitted diseases
Osteoporosis	Increased urinary frequency	Vaginal itching
Ovarian cysts	Uterine cysts / fibroids	Low or no desire for sex
Hysterectomy	Infertility	

MUSCULOSKELETAL

Pain in fingers	Bones sore/painful	Weakness
Chronic pain	Arthritis	Osteoporosis
Joint pain or stiffness	Bone deformity	Back pain
Calcium deposits	Stiff in morning	Athletic injury
Herniated / slipped disc	Broken bones	Tingling/burning in hands or feet
Injure easily	Tendonitis	Tightness in shoulder muscles
Pain in arms / hands	spasms /cramps /restless muscles	Swollen knees/elbows
Loss in height	Numbness in the extremities	Unable to sit straight
Double-jointed	Pain in neck and/or shoulders	Bursitis

PAIN

Please mark any areas of discomfort in the pictures below



How long have you had this pain? _____
 Quality of pain (eg. Sharp, stabbing, burning, achy, dull ect.) _____
 Is this pain constant or does it come and go? _____
 How frequently do you have pain _____

Is your pain better or worse with... (**B** for better/ **W** for worse):

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Movement | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Cold |
| <input type="checkbox"/> Pressure/Massage | <input type="checkbox"/> Morning |
| <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |

Rate your pain 0-10

