Debra Clapp, ND
Naturopathic Physician
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1213 14th Street **Anacortes, WA 98221** **(360) 299-9038**

NEW PATIENT HEALTH HISTORY

Today's Date ____

Name ____

Date of Birth ________________________________ Age _________ Blood Type _________ M or F

Address __________________________________ Best Phone(s) ___________________________

____ Email __________________________________

____ Occupation ______________________________

Living Situation: Single, or Live with: Spouse/Partner, Children, Parent(s), Pet(s), Other(s):

____.

In case of emergency, notify: ____

Relationship to you ___________________________ Phone(s) ____________________________

How did you hear about this office? ____

ALL INFORMATION YOU GIVE WILL REMAIN CONFIDENTIAL UNLESS YOU AUTHORIZE ITS RELEASE.
GOVERNMENT EMPLOYERS AND INSURANCE COMPANIES MAY REQUIRE RELEASE OF MEDICAL RECORDS.

MAIN CONCERNS Today:

____

____

____

____

List any known **ALLERGIES/REACTIONS** to foods, animals, dust, pollens, drugs, or other agents, and describe symptoms:

____

____

____

____

List **MEDICATIONS** and **SUPPLEMENTS** you are taking, prescription and over-the-counter, with dosages:

____

____

____

____

____
~~~~~~

Name _____ Date _____

Do you have any **CURRENT HEALTH CONDITIONS** and other health care providers?

Health Condition How & When Treated Treated by Whom?

_____

_____

_____

As applicable, what is the approximate date of your last, **MOST RECENT**: Blood **TEST** _____,

Pap test _____, PSA test _____, Mammogram _____, Colon or Sigmoid-oscopy _____,

Bone density test and kind (DEXA, ultrasound, of what area) _____,

Adult/Work/Travel Vaccinations, and kinds: _____,

Diagnostic imaging such as x-rays, MRI's, ultrasound _____ ,

Other: _____

PAST MEDICAL HISTORY

Please describe any injuries, surgeries, hospitalizations, blood transfusions, major illnesses, adult vaccinations, mental/emotional problems:

Health Condition Dates or Ages How Treated

_____

_____

_____

_____

_____

FAMILY HEALTH HISTORY (please include age or age at death, if applicable)

Please indicate if any family members have had heart disease, high blood pressure, stroke, diabetes, asthma, allergies, eczema, cancer, autoimmune disorder, epilepsy, mental illness, alcoholism/drug addiction, glaucoma, cataracts, or other significant health problems.

Your Mother, age	
Your Father	
Your Siblings	
Your Children	
Your M. Grandparents	
Your P. Grandparents	

Name _____ Date _____

LIFESTYLE

Do you enjoy your work? _____

How much time do you spend outdoors? _____

Are you **EXPOSED** to heavy metals, toxic chemicals, mold, or second-hand smoke at work, at home, or from your hobbies? Do you have any other exposures to **HAZARDOUS SITUATIONS**?

_____

_____

_____

_____

0n a scale of one to ten, with ten being worst, rate your **STRESS LEVEL**: 1 2 3 4 5 6 7 8 9 10
Main sources of negative stress:

_____

_____

_____

Main sources of relaxation, recreation, **REJUVENATION** (might include main interests, activities, spiritual practice)

_____

_____

_____

_____

How many hours do you **SLEEP** at night? _____ Do you awaken refreshed? Yes No
Do you have problems falling or staying asleep?

On a scale of one to ten, with ten being great, rate your **ENERGY**: 1 2 3 4 5 6 7 8 9 10

Are your daily tasks and plans affected by being tired? _____

PHYSICAL ACTIVITY

What kinds of physical activity or exercise? For how long? How often?

_____

_____

_____

_____

_____

Name _____ Date: _____

DIET

Favorite Foods: _____

Disliked Foods: _____

Are you satisfied with your diet? _____

What kinds of **FLUIDS** do you drink daily, and how much?

_____

_____

_____

Please list the foods, fluids, and amounts you eat in a typical day, or in the past 24 hours:

Breakfast	Lunch	Dinner	Snacks

What are your main sources of **Vegetable PROTEINS** (such as nuts, seeds, legumes, leafy greens, mushrooms)?

What are your main sources of **Animal PROTEINS** (such as meats, poultry, fish, dairy, eggs)?

What are your main sources of **CARBOHYDRATES** (starches and sugars, may be simple or complex, and include foods such as bread, pasta, cereals, baked goods, grains, potatoes, yams, squashes, bananas, fruit, vegetables)? Carbohydrates are also in foods such as dairy and legumes, but for now we'll leave those foods in the protein sections.

Name _____ Date _____

REVIEW OF SYSTEMS: Please underline or circle symptoms that are current or recent.

CONSTITUTION
Fatigue/Tiredness, unusual weight gain or weight loss, appetite changes, fever, chills, night sweats

SKIN
Rash, itching, dryness, flaking, oily skin, sores, changes in moles, growths or bumps, hair loss/thinning, brittle or problem nails.

BLOOD & LYMPH
Anemia, swollen lymph nodes, frequent nose bleeds, easy bruising.

NERVOUS SYSTEM
Headaches, migraines, spinning sensation, light-headedness, fainting, unsteady gait, poor balance, numbness, tingling, tremors, less ability to focus and concentrate, poorer memory, altered thinking abilities, moodiness or irritabilitiy, concussion.

EYES
Double visions, other vision problems, eye pain, eye redness, tearing, itching, dryness, lumps, eyelid or lash problems, floaters, flashes.

EARS
Ringing in ears, poor hearing, earache or pain, itching, dizziness, hearing aids.

NOSE & SINUSES
Frequent colds, nasal congestion/stuffiness, runny nose, post-nasal drip, frequent sinusitis, sinus headaches, loss of smell, hayfever/allergies, snoring, nasal polyps.

MOUTH & THROAT
Frequent sore throats, sore or bleeding gums, grinding teeth, mouth sores, hoarseness, decreased sense of taste, dental problems, difficulty swallowing, neck lumps.

BREASTS
Lump(s), change in shape or contours, change in size, tenderness or pain, nipple discharge, skin changes.

LUNGS
Difficulty breathing (while lying down, on exertion, in middle of night, on taking a deep breath), shortness of breath, coughing, wheezing, frequent bronchitis, asthma, other lung disorders.

HEART & VESSELS
Chest pain, heartbeats that are skipped/fast/extra strong, irregular heart beats, high blood pressure, varicose veins, clotting problems, leg cramps when walk, ankle or leg swelling, leg pain, cold/discolored extremities, heart murmur, angina, history of heart attack or stroke/TIA.

DIGESTION
Difficulty swallowing, acid reflux, ulcer, nausea, vomiting, diarrhea, constipation, abdominal bloating/distension, abdominal pain or cramping, excessive gas, hemorrhoids, rectal bleeding, change in stool, gallstones, jaundice, poor digestion.
Do you use antacids, laxatives, or aspirin?

KIDNEYS & BLADDER
Frequent bladder infections. Loss of bladder control.
Urination that is difficult, painful, urgent.
Increased or decreased frequency of urination.
Awaken to urinate at night. Loss of bladder control.
Change in total daily urine output.
Change in color or smell of urine. Kidney stones.
Difficulty starting stream, reduced force of stream.

MUSCULO-SKELETAL
Problems with bones, joints, &/or muscles at: neck, back, hips, knees, ankles, feet, shoulders, elbows, wrists, hands.
Aching, stiffness, swelling, redness, limited range of motion, reduced daily activities, injuries, dislocations, osteoporosis, muscle weakness, muscle cramps.

ENDOCRINE/HORMONES
Extremely thirsty, hungry, and urinate more than 3 quarts per day.
Nervousness, sweaty palms, shakiness, mental confusion, headaches.
Feel hot or cold most of the time, more than others.
Easy to lose or gain weight, brittle or thinning hair, dry or perspiring skin, irregular menstrual periods, unusual difficulty thinking, unusual depression.
Diabetes, hypoglycemia, goiter, thyroid problems, adrenal problems.

Name _____ Date _____

PSYCHE

Anxiety or nervousness, panic attacks, mood swings, depression, loss of enthusiasm and motivation, low energy, eating more or less than usual, sleeping more or less than usual.

Hopeless about it all? Ever thought of suicide? Plans? Tried it? _____

Do you see or hear things other people don't (hallucinate)? _____ Disturbing, repetitive thoughts? _____

MEN

Testicular swelling, lump, or pain. Penile discharge, sores, pain, numbness, erection difficulty, infertility.

Change is sex drive or sexual function _____

Ever had any sexually transmitted diseases? _____

WOMEN

Periods began at age: _____

Date that last menstrual period started: _____ (if menopausal, year or approximation is fine)

Number of flow days: _____

How long is cycle? _____

Irregular cycles, missed periods, bleeding between cycles,

Menstrual cramps, heavy bleeding, PMS,

Vaginal discharge, itching, sores, pain, dryness, numbness,

Change in sex drive or sexual function? _____

Ever had any sexually transmitted diseases? _____

Difficulty conceiving, infertility.

Forms of contraception used currently and in the past:

_____

Number of pregnancies _____ number of children born _____ number of miscarriages/abortions _____

Any Pap test ever abnormal? **NO YES** if so, when: _____

Any surgeries of reproductive organs? If so, what and when? _____

Hot flashes, night sweats, insomnia, unusual moodiness?

SUBSTANCE USE	If so, When and For How Long?	Last Time?	How Much & How Often?
Tobacco			
Alcohol			
Caffeine			
Street Drug(s)/Type:			

PUBLIC HEALTH CONCERNS: Written answers **NOT** required. Please be aware of this information and your risks.

1. HIV can be transmitted by contact with:
   semen/ejaculate, broken skin or broken mucus membranes, blood, or vaginal fluids of infected persons.
2. Birth control pills do NOT protect against sexually transmitted diseases.
3. Are any sex partners at risk for HIV? That is:
   use intravenous drugs and share needles,
   are men who have sex with men,
   had blood transfusions from 1979-1985,
   exchange sex for money or drugs,
   have other sexually transmitted diseases, or
   have more than one sexual partner.

- Do you have sex with men, women, or both?
- Do you have a steady sexual partner?
- When did you last have sex with someone other than your steady partner?