Natural Health Clinic of Olympia • 3624 Ensign Rd. NE Suite B • Olympia, WA 98506 • 360-491-4131

Adult Medical History Form

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present concerns**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REVIEW OF SYMPTOMS:Please check any current symptoms you may have on the list below

*Constitutional*

*\_\_*Fevers/sweats/weakness

\_\_Unexplained weight loss/gain

\_\_Dizziness

*Eyes*

*\_\_*Change in vision

*Ears/Nose/Throat/Mouth*

*\_\_*Difficulty hearing/ringing in

 ears

\_\_Hay fever/allergies

*Cardiovascular*

*\_\_*Chest pain/discomfort

\_\_Palpitations

*Breast*

*\_\_*Breast lump/nipple discharge

*Respiratory*

*\_\_*Cough/wheeze

*Gastrointestinal*

\_\_Blood/mucus in stool

\_\_Loose stools/diarrhea

\_\_Hard/dry stools

\_\_Acid reflux

\_\_Poor appetite

\_\_Always hungry

\_\_Bloating/gas

*Genitourinary*

\_\_Nighttime urination

\_\_Leaking urine

*Musculoskeletal*

*\_\_*Muscle/joint pain

*Skin*

*\_\_*Rash/new or change in mole

*Neurological*

*\_\_*Headaches

\_\_Memory loss

*Psychiatric*

\_\_Anxiety/stress

\_\_Sleep problem

\_\_Depression

*Blood/Lymphatic*

\_\_Unexplained lumps

\_\_Easy bruising/bleeding

*Other*

*\_\_*Concern with sexual function

Circle your energy level: Fatigue—1—2—3—4—5—6—7—8—9—10—High Energy

Amount of bowel movements per day\_\_\_\_\_\_\_ Amount of water you drink per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past month, have you had little interest or pleasure in doing things or felt down, or hopeless? □ Yes □ No

MEDICATIONS AND SUPPLEMENTS:

Medication Dose (mg/pill) How many times per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies or reactions to medicines:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH MAINTENANCE SCREENING TESTS:

Cholesterol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_ Abnormal? □ Yes □ No

Sigmoidoscopy\_\_\_\_\_or Colonoscopy\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_ Abnormal? □ Yes □ No

Women: Mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_ Abnormal? □ Yes □ No

 Pap smear\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_ Abnormal? □ Yes □ No

WOMEN’S HEALTH HISTORY: **#** pregnancies\_\_\_ # deliveries\_\_\_# abortions\_\_\_# miscarriages­\_\_\_

1st day of most recent period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any pain with period or PMS? □ Yes □ No

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PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following conditions

\_\_Heart attack

\_\_High blood pressure

\_\_Diabetes

\_\_High cholesterol

\_\_Thyroid disease

 Specify type\_\_\_\_\_\_\_\_\_\_\_

\_\_Cancer

 Specify type\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Heart disease

 Specify type\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Stroke

\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SURGICAL HISTORY:Please list all prior operations (with dates)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions

Alcoholism\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer, specify type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart attack\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression/suicide\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High cholesterol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High blood pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL HISTORY:

**Tobacco use**

Cigarettes □ Never □ Quit date\_\_\_\_\_\_\_\_\_\_\_

□ Current smoker: packs/day\_\_\_\_ # years\_\_\_\_\_\_\_\_\_

Other tobacco: □ Pipe □ Cigar □ Chew

**Alcohol use**

Do you drink alcohol? □ Yes □ No

 # drinks/week\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug use**

Do you use any recreational drugs? □ Yes □ No

Have you used needles to inject drugs? □ Yes □ No

**Caffeine intake**

How many cups per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Soda**

How many servings per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Daily food intake**

Please list your typical breakfast, lunch and dinner

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any foods you restrict from your diet?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise**

Do you exercise regularly? □ Yes □ No

What kind of exercise\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long \_\_\_\_\_\_\_\_\_\_\_\_\_How often \_\_\_\_\_\_\_\_\_\_\_\_

**Safety**

Is violence at home a concern for you? □ Yes □ No

Have you ever been abused? □ Yes □ No

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: □ Single □ Partnered/married

□ Divorced □ Widowed

Number of children/ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_