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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Name_____Date_____Date of Birth_____

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:_____