Meghan Van Vleet, ND
Doctor of Naturopathic Medicine

Adult Patient Health History

Today's Date: ____________________

Patient's Name: ____
(Last) (First) (Middle)

Age: _________ Birthdate: _________________ SS#: ______________________________ Gender: M F
(Disclosure of your social security number is voluntary and optional)

Occupation: ____

Address: ____
(Street, City, State, Zip)

Mailing Address (if different): ____
(Street, City, State, Zip)

E-mail address: ____

Phone(s): ____
(Home) (Work) (Other)

What is your current living and relationship situation? ____

____

Emergency contact: ____
(Name) (Phone)

Relationship: ____

Who is your primary care physician: ____
(Physician's Name)

Address: ____

How did you learn about my practice? ____

What are your most important health concerns in order of importance?

1. ____
2. ____
3. ____

When and where did you last receive healthcare? ____

What was the reason? ____

Please list traumatic events in your life that you believe have impacted your health: ____________________

____

CHILDHOOD ILLNESSES (Y=yes, N=never, ?=not sure)

Measles (14-day Rubeola) ____
Mumps ____
Frequent colds ____
Strep throat ____
Pneumonia ____
Tonsillitis ____

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Rubella (3-day German measles) ____
Chickenpox ____
Skin rashes ____

Scarlet Fever ____
Rheumatic Fever ____
Herpes ____

Ear Infections ____
Diabetes ____

Chronic diarrhea or constipation ____

Other (please list) ____

IMMUNIZATIONS

MMR (measles, mumps, rubella) ____
DPT (diptheria, pertussis, tetanus) ____
Polio ____

Chickenpox ____
Tetanus ____

Influenza (flu) ____
Hepatitis ____

Others (please list) ____

HOSPITALIZATIONS & SURGERIES (list reason &/or type of surgery and date): ____________________

____

____

SCREENINGS/EVALUATIONS (list the date of your last screening):

Blood work (type): ________________

Pap smear & result: ________________

Mammogram: ________________

Testicular exam: ________________

Prostate exam: ________________

Bone densitometry: ________________

Physical: ________________

EKG: ________________

X-ray: ________________

ALLERGIES Please list known allergies to medication, food, or environment: ____________________

____

____

ENVIRONMENTAL EXPOSURE Are you aware or do you suspect that you have been exposed to toxic substances in your home or work environment? Please describe: ____________________

____

____

MEDICATIONS

	Now	Past
Antibiotics	____	____
Decongestants	____	____
Anti-histamine	____	____
Inhalers	____	____
Insulin	____	____
Diet pills	____	____
Antacids	____	____
Thyroid medication	____	____

	Now	Past
Hormones	____	____
Antidepressants	____	____
Sleeping pills	____	____
Tranquilizers	____	____
Pain relievers	____	____
Cortizone	____	____
Laxatives	____	____

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Others: ____

List all current medications, dosage, and reason for taking (or attach a list)

____

____

List all current vitamins/supplements/herbs/homeopathics, dosage, and reason for taking (or attach a list)

____

____

FAMILY HISTORY

Check those applicable	Father	Mother	Sibling	Spouse	Child
Age (if living)	______	______	______	______	______
Health: G=good P=poor	______	______	______	______	______
Cancer (type?)	______	______	______	______	______
Diabetes	______	______	______	______	______
Heart disease	______	______	______	______	______
High blood pressure	______	______	______	______	______
High cholesterol	______	______	______	______	______
Stroke	______	______	______	______	______
Epilepsy	______	______	______	______	______
Mental illness	______	______	______	______	______
Asthma, hay fever, hives	______	______	______	______	______
Anemia	______	______	______	______	______
Kidney disease	______	______	______	______	______
Gallbladder disease	______	______	______	______	______
Liver disease	______	______	______	______	______
Osteoporosis	______	______	______	______	______
Ulcer	______	______	______	______	______
Tuberculosis	______	______	______	______	______
Rheumatoid arthritis	______	______	______	______	______
Thyroid disease	______	______	______	______	______
Age deceased	______	______	______	______	______
Cause of death	______	______	______	______	______

Other ____

PRENATAL/BIRTH/NEONATAL HISTORY (if known)

Mother's health during pregnancy

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Hypertension ____ Smoking, alcohol, drug use ____________________
Diabetes ____ Physical or emotional trauma ____________________
Thyroid problems ____ Illnesses ____________________

Medications ______________________________________

Mother's age at birth of child: _________

Term: Full ____ Premature ____ Late ____ Birth wt: ______lbs____oz

List complications during labor or at birth: ______________________________

____

Neonatal complications (ie: colic, jaundice, heart murmur) ______________________

HABITS

What are your main interests and hobbies? ______________________________

____

Do you exercise? Y N What forms and how often? ______________________

____

Diet
Do you eat three meals daily? Y N Blood Type? A B AB O
Please describe a typical daily diet:

Breakfast ______________________________________

Lunch ______________________________________

Dinner ______________________________________

Snacks ______________________________________

How many glasses of water do you drink daily? _______
Do you drink caffeinated products? Y N If so, what kind? ____________________

Do you have any food intolerances that you know of? Y N If yes, please explain ____________

____

Sleep
Do you sleep well? Y N
Awaken rested? Y N
Average 6-8 hrs sleep per day? Y N
Work
Work unusual hours? Y N
Enjoy your work? Y N
Take vacations? Y N
Other
Spend time outdoors? Y N Hours/day? __________
Read? Y N
Spend time in front of the TV? Y N Hours/day? __________
Do you have a spiritual practice? Y N
Ever use tobacco? Y N How much? _________ How long? __________
Drink alcohol? Y N How much? __________
Been treated for alcoholism? Y N
Use recreational drugs? Y N
Been treated for drug abuse? Y N

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REVIEW OF SYSTEMS (Y=yes, P=past, N=never)

General

Weight ______________

Satisfied with wt? Y / N

Weight 1 yr ago _______

Maximum wt __________

When? _______

Height _______________

Fatigue	Y	P	N
Night sweats	Y	P	N

Skin

Hives	Y	P	N
Eczema	Y	P	N
Chronic rash	Y	P	N
Acne, boils	Y	P	N
Itching	Y	P	N
Color change	Y	P	N
Lumps	Y	P	N
Herpes	Y	P	N
Loss of hair	Y	P	N
Psoriasis	Y	P	N

Head

Headaches	Y	P	N
Head injury	Y	P	N
Jaw/TMJ problems	Y	P	N

Eyes

Change in vision	Y	P	N
Double vision	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N
Floaters	Y	P	N
Eye pain	Y	P	N
Tearing or dryness	Y	P	N
Glasses or contacts	Y	P	N

Ears

Impaired hearing	Y	P	N
Ringing	Y	P	N
Dizziness	Y	P	N
Earache	Y	P	N

Nose/sinuses

Frequent colds	Y	P	N
Stuffiness	Y	P	N
Loss of smell	Y	P	N
Sinus infections	Y	P	N
Hay fever	Y	P	N
Frequent nose bleeds	Y	P	N

Mouth & throat

Frequent sore throat	Y	P	N
Canker sores	Y	P	N
Sore/swollen tongue	Y	P	N
Sore lips	Y	P	N
Bleeding/receding gums	Y	P	N
Dental cavities	Y	P	N
Toothache/sensitivities	Y	P	N
Difficulty swallowing	Y	P	N
Hoarseness	Y	P	N
Frequently clear throat	Y	P	N

Neck

Lumps	Y	P	N
Swollen glands	Y	P	N
Goiter	Y	P	N
Pain or stiffness	Y	P	N

Respiratory

Wheezing	Y	P	N
Asthma	Y	P	N
Emphysema	Y	P	N
Difficulty breathing	Y	P	N
Cough	Y	P	N
Productive cough	Y	P	N
Bronchitis	Y	P	N
Shortness of breath	Y	P	N
At night?	Y	P	N
Lying down?	Y	P	N
Pain on breathing	Y	P	N
Pneumonia	Y	P	N
Pluerisy	Y	P	N
Tuberculosis	Y	P	N

Cardiovascular

Fainting	Y	P	N
Heart disease	Y	P	N
Chest pain/angina	Y	P	N
Low/high blood press.	Y	P	N
High cholesterol	Y	P	N
Fluttering in chest	Y	P	N
Heart murmur	Y	P	N
Rheumatic fever	Y	P	N
Swelling in ankles	Y	P	N

Gastrointestinal

Change in thirst	Y	P	N
Change in appetite	Y	P	N
Nausea	Y	P	N
Frequent indigestion	Y	P	N
Vomiting	Y	P	N
Vomiting blood	Y	P	N
Blood in stool	Y	P	N
Black stool	Y	P	N
Abdominal pain	Y	P	N
Gallbladder pain	Y	P	N
Liver disease/hepatitis	Y	P	N

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Jaundice Y P N
Frequent belching/gas Y P N
Heartburn Y P N
Ulcers Y P N
Hemorrhoids Y P N
Constipation Y P N
Diarrhea Y P N
Bowel movements
How often? ___________
Is this a change? Y / N

Urinary
Pain on urination Y P N
Increased frequency Y P N
Frequency at night Y P N
Inability to hold urine Y P N
Bloody urine Y P N
Frequent infections Y P N
Kidney stones Y P N

Breasts
Do you self-exam? Y P N
Lumps Y P N
Pain or tenderness Y P N
Nipple discharge Y P N

Female reproductive
Age of 1st menses ____________
Regular cycles Y P N
Skipped cycles Y P N
Length of cycle ______________
Duration of menses ___________
Painful menses Y P N
Heavy flow Y P N
Bleeding b/w periods Y P N
PMS Y P N
Menopausal symptoms Y P N
Age of last menses (if menopausal) ____
Sexually active Y P N
Pain with intercourse Y P N
Birth control Y P N
What type? ___________
# of pregnancies _____________
# of live births ________________
# of miscarriages _____________
# of abortions ________________
Difficulty conceiving Y P N
Ovarian cysts Y P N
Sexually transmitted disease
Y P N
Sexual difficulties Y P N
Frequent vaginal infect. Y P N
Sexual preference
Heterosexual Y P N
Bisexual Y P N
Homosexual Y P N

Date of last annual exam ______
Abnormal pap Y P N
Cervical dysplasia Y P N

Male reproductive
Hernias Y P N
Testicular lump Y P N
Testicular pain Y P N
Prostate disease Y P N
Sexually active Y P N
Birth control Y P N
What type? ___________
Sexual difficulties Y P N
Difficulty conceiving Y P N
Sexually transmitted disease
Y P N
Discharges or sores Y P N
Sexual preference
Heterosexual Y P N
Bisexual Y P N
Homosexual Y P N

Musculoskeletal
Joint pain/stiffness Y P N
Arthritis Y P N
Broken bones Y P N
Osteopenia Y P N
Osteoporosis Y P N
Muscle spasms/cramps Y P N

Peripheral vascular
Thrombophlebitis Y P N
Varicose veins Y P N
Cold hands/feet Y P N
Deep leg pain Y P N

Blood
Anemia Y P N
Easy bleeding/bruising Y P N

Neurological
Head injury Y P N
Stroke Y P N
Seizures Y P N
Fainting Y P N
Loss of coordination Y P N
Paralysis Y P N
Numbness or tingling Y P N
Memory loss Y P N
Loss of taste or smell Y P N
Loss of balance Y P N
Muscle weakness Y P N

Endocrine
Hyperthyroid Y P N
Hypothyroid Y P N

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Heat/cold intolerance	Y	P	N	Feel out of control	Y	P	N
Diabetes	Y	P	N	Feel stressed out	Y	P	N
Excessive thirst	Y	P	N	Feel nervous	Y	P	N
Excessive hunger	Y	P	N	Indecisive	Y	P	N
Excessive urination	Y	P	N	Feel isolated	Y	P	N
Excessive fatigue	Y	P	N	Uncontrolleld anger	Y	P	N
				Feel afraid	Y	P	N
Emotional				Loss of self-esteem	Y	P	N
Anxiety	Y	P	N	Feel victimized	Y	P	N
Depression/sadness	Y	P	N	Anorexia/bulimia	Y	P	N
Mood swings	Y	P	N				

Naturopathic Medical Consent: I, the undersigned, consent to naturopathic care and treatment by Meghan Van Vleet, ND.

Financial Agreement: I, the undersigned, acknowledge that I am financially responsible for all charges, and agree to pay Meghan Van Vleet, ND in accordance with her regular rates and terms. All payment is due at time of service, unless alternative arrangements have been made prior to services being rendered. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Meghan Van Vleet, ND to release information necessary to secure payment.

I, the undersigned, certify that the information I have supplied is correct and accurate to the best of my knowledge.

Signature: ____ Date: ______________

Thank You.

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