ARIZONA
NATUROPATHIC MEDICINE LLC

Patient Medical History

Patient Name: _____ **Date of Birth/Age:** _____ **Date:** _____

What is the primary reason for your visit? __ I have an illness/injury or other concern:_____
__ Consultation only __ Are you an established patient at this office? __Y __N
__ Are you establishing care at this office? __Y __N

Please identify your primary provider (if you have one): __I do not have a primary provider

_____ _____
Name Location

Please explain your health concern, including how long this has been a concern and the level of significance you place on the matter:

_____
_____

Have you been diagnosed with any chronic disease? __Y __N If yes, please list them here:

_____ _____ _____

Current Medications:
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____

Current Supplements:
__ Multiple Vitamin (Brand: _____)
Supplement: _____ Dose: _____ Frequency: _____
Supplement: _____ Dose: _____ Frequency: _____
Supplement: _____ Dose: _____ Frequency: _____
Supplement: _____ Dose: _____ Frequency: _____

Do you have drug or food allergies? __Y __N
Explain: _____

Smoking History:
Do you currently smoke? NO __ Yes: Cigarettes __ (Packs per day) Cigars __ (Cigars/day) Pipe __ (Times/day) Vape: _____
Do you want to quit smoking? __Y __N

Bowel Movements:
How many bowel movements do you typically have each day: 0—1—2—more
How would you describe your recent stools?
__Solid, well formed; no strain to pass __Hard; difficult to pass __Loose/Diarrhea
__Foul-smelling __Floating __Greenish __White/Clay-colored
__Use laxatives

Have you recently noticed blood on the tissue or in the water after your stool: **Y N**
Have you noticed or suspected hemorrhoids: **Y N**

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Energy Level:

What has your energy level been for the past several days? 1--------5--------10 (10 is best)
How much sleep is normal for you? 4—6—8 –10 hours per night

Stress: How would you rate your current stress level: 1--------5--------10 (10 is worst)
What is the primary cause of your stress? _____

Occupation: What type of work do you do?

__Full-time Student __Part-time student __Retired; How long? _____
__Teacher/Instructor __Hospitality __Entertainment/Sports
__Service Industry __Landscape/Pest Control __Auto Repair
__Outside Sales __Retail Sales __Research
__Office Type of business: _____
__Healthcare Type of clinic or facility: _____
Other: _____

Social History:

__Past or current alcohol use Date of last use: _____ Alcohol volume/day: _____ N/A

__Alcohol Dependency Are you a recovering alcoholic? **Y N** (Some medications are alcohol-based)
__Current recreational drug use Drugs used: _____
__Prescription Drug Dependency Drug(s): _____

Do you exercise on a regular basis? Y N If yes, please describe the type and frequency of your exercise**:**
_____

Hospitalizations: Age/Reason _____
Age/Reason _____
Age/Reason _____
Surgeries: Age/Reason _____
Age/Reason _____

Have you recently had any laboratory studies or imaging (x-rays, CT, MRI, UltraSound) Y N

Recent Labs: CMP CBC/Diff TSH Other: _____
Recent Imaging: X-rays CT Scan MRI Details: _____

Were any of the results concerning? __Y __N

The requested information on the following pages are gender specific.

Men Only

▪ Do you experience pain with urination?	Y N
▪ Have you recently noticed a discharge from your penis?	Y N
▪ Have you recently noticed a wart, growth, or sore in your genital region?	Y N
▪ If yes, have you ever been evaluated for or diagnosed with a sexually transmitted infection?	Y N
▪ Do you have any difficulty beginning or maintaining a stream of urine?	Y N
▪ Do you frequently need to get up during sleep to urinate?	Y N
▪ Have you recently noticed blood in your urine?	Y N
▪ Are you satisfied with the currently flow of urine?	Y N
▪ Have you ever been evaluated for, or diagnosed with: ___BPH ___Prostate Cancer	Y N
▪ Do you have difficulties achieving or maintaining an erection?	Y N
▪ Do you have difficulties achieving climax?	Y N
▪ Do you think or say things such as “I’ve lost my mojo” or “I don’t have the drive I used to have?”	Y N
▪ Do you find that you are constantly fatigued?	Y N
▪ Do you have low sex drive/libido?	Y N
▪ Are you sometimes depressed?	Y N
▪ Do you have anxiety, or are you easily agitated?	Y N
▪ Have you been diagnosed with, or wondered about, low testosterone?	Y N
▪ Have you ever noticed blood in your stool?	Y N
▪ Have you ever had a colonoscopy? If yes, date of most recent exam:	Y N

Patient Acknowledgment: _____ _____

(Signature) (Date)

Women Only

- Your age when you began to have a monthly cycle (menarche): _____ years

Children: Number: ____ PGYs: ____ Date of your last PAP exam: _____
Result: _____

- Have you noticed warts, sores or red areas in your genital area? **Y N**
- Have you had a hysterectomy? **Y N**
  - If yes:
    - Your age at the time of the hysterectomy: _____
    - Was your uterus removed? **Y N**
    - Were your ovaries removed? **Y N**
    - Are you currently using any hormones? __Estrogen __Progesterone __Other
- Have you ever been diagnosed with cancer of the: __Vulva __Cervix __Uterus __Ovaries

- Current and Recent Sexual Habits: __Active __Not Active
  __Monogamous Is your partner Monogamous Y **N**
  __Multiple Partners __Heterosexual __ Homosexual __Bisexual

Breast Health

- Have you ever been diagnosed with breast cancer **Y N**
  - If yes, did you undergo any of the following treatments:
    __Radical mastectomy __Lumpectomy __Removal of Lymph Nodes
    __Chemotherapy __Radiation therapy __Other: _____

Date of last mammogram: _____ Date of last clinical breast exam: _____	
Do you perform monthly breast self-exams?	**Y N**
Have you noticed any lumps, bumps, dimpling?	**Y N**
Do you experience breast pain during menstrual periods?	**Y N**
Have you noticed unusual nipple discharges?	**Y N**

Non-menopausal: Last menstrual period (start of bleeding): _____
How heavy is your period? Days____ Pads____ Tampons ____
Do you observe blood clots? **Y N**
Do you experience PMS? **Y N**

- Are you trying to become pregnant? **Y N**
- Are you currently using any form of birth control? **Y N**

In Menopause: When was your last period: ____ months ago
Are you currently experiencing symptoms of menopause: **Y N**

Post-menopausal: At what age did you enter menopause: ____ years of age
Have you experienced any of the following:
__vaginal dryness or itching __pain with intercourse
Are you currently using any hormones? __Estrogen __Progesterone __Other _____

Patient Acknowledgment: _____ _____
(Signature) (Date)