

# Nourishing Medicine

## Patient Health History

Please note that all information is kept confidential.

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ DOB \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

Phone (home) \_\_\_\_\_ Phone (cell) \_\_\_\_\_

Is it all right to leave a message about your care at this number? Yes / No

Emergency Contact \_\_\_\_\_

Relationship & Phone # \_\_\_\_\_

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

How did you hear about Nourishing Medicine? \_\_\_\_\_

Please list the health concerns you would like to address in order of importance:

1. \_\_\_\_\_ Date of onset: \_\_\_\_\_

2. \_\_\_\_\_ Date of onset: \_\_\_\_\_

3. \_\_\_\_\_ Date of onset: \_\_\_\_\_

How does this condition affect your daily activities/work/relationships/emotions?

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

What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? Rate 0-10 where 10 is 100% commitment:

0 1 2 3 4 5 6 7 8 9 10

### Lifestyle & Fundamental Aspects of Good Health

Do you sleep well? Y / N Average Number of Hours of Sleep \_\_\_\_\_

Do you exercise or "get out and move" regularly? Y / N List: \_\_\_\_\_

Do you feel you drink enough water each day? Y / N How much? \_\_\_\_\_

Do you feel like you have a generally healthy diet? Y / N

Where do you eat out? \_\_\_\_\_

Do you tend to have cravings? Y / N What are they? \_\_\_\_\_

Do you consume/use alcohol, caffeine, tobacco or any other drug/substance? If so, which ones and how much per week? \_\_\_\_\_

What is your current occupation? \_\_\_\_\_ How many hours/week: \_\_\_\_\_

Do you enjoy your work? Y / N Why? \_\_\_\_\_

Who do you know, if anyone, that will consistently support the beneficial lifestyle changes you will be making? \_\_\_\_\_

What do you *love* to do? \_\_\_\_\_

Does your home life support you **or** add to your stress? \_\_\_\_\_

What aspects of your life help you support good health? \_\_\_\_\_

What aspects of your life compromise your ability to support good health? \_\_\_\_\_

Please list all medications/supplements/vitamins you are currently taking.

Name / Dosage

Reason

For How Long

Name / Dosage	Reason	For How Long

Please list all major accidents, illnesses, surgeries and hospitalizations and when they occurred.


Please list all Diseases or Conditions that you are currently diagnosed with or believe you may have: \_\_\_\_\_


Please list any allergies you have and your response to them (medications, foods, animals, environmental substances, etc.). \_\_\_\_\_


Are you or might you currently be pregnant? Y / N

Do you have a pacemaker? Y/N Heart Murmur? Y / N

Do you have a history of seizures? Y / N Fainting? Y/ N

Chronic Infections, Please check all that apply:

\_\_\_ Tuberculosis

\_\_\_ Hepatitis A/B/C

\_\_\_ STD

\_\_\_ HIV

\_\_\_ AIDS

\_\_\_ Other

1 = rarely    2 = occasionally    3 = frequently    4 = always

*If you do not experience the symptom at all, you can leave it unmarked.*

### Energy & Stress

- 1 2 3 4 fatigue / low energy
- 1 2 3 4 symptoms are worse with exercise
- 1 2 3 4 symptoms are better with exercise
- 1 2 3 4 symptoms are worse with stress
- 1 2 3 4 heavy sensation of the body
- 1 2 3 4 unclear or foggy thinking
- 1 2 3 4 hands & feet feel cold

### Musculo-Skeletal

- 1 2 3 4 muscle tightness/achiness
- 1 2 3 4 muscle spasms / cramping
- 1 2 3 4 frequent sprains or strains
- 1 2 3 4 joint pain / stiffness

### Neurological Function

- 1 2 3 4 muscle weakness
- 1 2 3 4 numbness / tingling
- 1 2 3 4 loss of sensation / function
- 1 2 3 4 paralysis
- 1 2 3 4 balance problems

### Cardiovascular

- 1 2 3 4 palpitations
- 1 2 3 4 chest tightness or pain
- 1 2 3 4 ankle / lower body swelling
- 1 2 3 4 varicose veins
- 1 2 3 4 high blood pressure
- 1 2 3 4 low blood pressure
- 1 2 3 4 fainting or dizziness
- 1 2 3 4 poor memory
- 1 2 3 4 pale face, nails or inside eyelids
- 1 2 3 4 blackouts / loss of consciousness

### Mental & Emotional Tendencies

- 1 2 3 4 anxiety / excess worry
- 1 2 3 4 panic attacks
- 1 2 3 4 obsessive / compulsive behaviors
- 1 2 3 4 easy to anger/irritability
- 1 2 3 4 indecisiveness
- 1 2 3 4 feelings of grief / sadness
- 1 2 3 4 feelings of worthlessness
- 1 2 3 4 frequent crying
- 1 2 3 4 difficulty concentrating / focusing
- 1 2 3 4 excess fear
- 1 2 3 4 make time to nurture yourself
- 1 2 3 4 feel generally positive and capable

### Gastro-Intestinal

- 1 2 3 4 low appetite
  - 1 2 3 4 big appetite
  - 1 2 3 4 fatigue after meals
  - 1 2 3 4 gas or bloating after meals
  - 1 2 3 4 acid reflux / heartburn
  - 1 2 3 4 belching
  - 1 2 3 4 nausea or vomiting
  - 1 2 3 4 stomach pain
  - 1 2 3 4 side or rib pain
  - 1 2 3 4 gallbladder stones
  - 1 2 3 4 intolerance of fatty foods
  - 1 2 3 4 constipation
  - 1 2 3 4 loose stools or diarrhea
  - 1 2 3 4 blood in stools
  - 1 2 3 4 mucous in stools
  - 1 2 3 4 undigested food in stools
  - 1 2 3 4 hemorrhoids
- Have you traveled outside of the U.S.? Y / N
- Have you ever had a parasite? Y / N

**Head, Eyes, Ears, Nose & Throat**

- 1234 headaches  
 1234 sinus congestion / pressure  
 1234 blurry vision / poor night vision  
 1234 ear ringing  
 1234 hearing loss  
 1234 nasal discharge  
 1234 nose bleeds  
 1234 dry nose / mouth / throat/eyes  
 1234 sore throat  
 1234 bleeding or swollen gums  
 1234 jaw pain or tightness

**Genito-Urinary**

- 1234 excess or frequent urination  
 1234 waking to urinate at night  
 1234 pain or burning with urination  
 1234 difficulty passing urine  
 1234 blood in the urine  
 1234 cloudy urine  
 1234 dribbling or incontinence  
 1234 kidney stones

**Endocrine & Immune Function**

- 1234 body tends to feel warm / hot  
 1234 body tends to feel cool / cold  
 1234 spontaneous daytime sweating  
 1234 night sweats  
 1234 skin problems (itch, rash, dry, acne)  
 1234 excess thirst  
 1234 hair loss or thinning  
 1234 unusual hair growth  
 1234 slow wound healing  
 1234 easy bruising

**Men's Health**

- 1234 testicular pain / swelling  
 1234 penile discharge  
 1234 low libido  
 1234 sexual difficulties  
 Have you had your prostate checked? Y / N

**Respiratory**

- 1234 catch cold easily (>3x/year)  
 1234 cough  
 1234 cough up of phlegm or blood  
 1234 asthma / difficulty breathing  
 1234 chest tightness or pain

**Women's Health**

- 1234 vaginal / labial pain or swelling  
 1234 excess vaginal discharge  
 1234 yeast infections  
 1234 nipple discharge  
 1234 breast lumps

self breast exam monthly? Y / N

- 1234 low libido

Types of protection/birth control used?

**Menstrual History & Patterns**

Date of last annual exam \_\_\_\_\_

Age of first period \_\_\_\_\_

Age at Menopause \_\_\_\_\_

Is your cycle regular? Y / N

Do you bleed between periods? Y / N

# of bleeding days \_\_\_\_\_

Total length of cycle (# of days) \_\_\_\_\_

Is your bleeding heavy / moderate / light?

Do you have clots? Y / N

Do you have cramping? Y / N

Cramping before / during / after menses?

Do you have PMS symptoms? Y / N

• Breast tenderness Y / N

• Emotional instability / mood swings Y / N

• Cravings Y / N, what? \_\_\_\_\_

**Pregnancy**

# of pregnancies \_\_\_\_\_

# of live births \_\_\_\_\_

# of miscarriages \_\_\_\_\_

# of abortions \_\_\_\_\_

