

WOMEN'S NATURAL HEALTH CENTER

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PATIENT'S PERSONAL HISTORY FORM

NAME: _____ Age: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

E-mail: _____ Home Phone: _____ Work Phone: _____

REFERRED BY: _____

Occupation: _____ Birth Place: _____ Birth Date: _____

Primary Care Physician: _____ Date of last Physical Examination _____

Chief Complaints: (Please list all symptoms. Attach an extra sheet if needed.)

1. _____
2. _____
3. _____
4. _____

Please answer each of the following questions by placing a [Check] in the "yes" box if your answer to the question is yes, or by placing a [check] in the "no" box if your answer to the question is no. Fill in "who" and "when" information when necessary.

FAMILY HISTORY

Has Any Blood Relative Ever Had:

Cancer, including Leukemia NO YES WHO _____

Tuberculosis NO YES WHO _____

Diabetes NO YES WHO _____

Heart Trouble NO YES WHO _____

Heart Attach NO YES WHO _____

High Blood Pressure NO YES WHO _____

Stroke NO YES WHO _____

Epilepsy NO YES WHO _____

Bleeding Disorder NO YES WHO _____

Asthma NO YES WHO _____

Allergies NO YES WHO _____

Liver Disease NO YES WHO _____

Migraine Headaches NO YES WHO _____

Alcoholism NO YES WHO _____

Kidney Disease NO YES WHO _____

Glaucoma NO YES WHO _____

Sickle Cell Anemia NO YES WHO _____

Family History (continued)

Other Anemia NO YES WHO _____

Suicide NO YES WHO _____

Birth Defects NO YES WHO _____

Other Serious Disease NO YES WHO _____

PERSONAL HISTORY

Do You Smoke? NO YES _____

If Yes, What How Much _____ How Many years _____

Do You Drink?

Beer NO YES _____

Wine NO YES _____

Other Alcoholic Beverages NO YES _____

How Much of Each? _____

Are You on a Special Diet? NO YES _____

What Diet? _____

	Living	Dead	Age at Death	Cause of Death
Father				
Mother				
Brother or Sister				
Husband or Wife				
Son or Daughter				

Personal History (continued)

Have you lost Weight in Past year? NO YES

Do You Have Difficulty Sleeping? NO YES

Are You Overweight? NO YES

X-RAYS

Have You Had Any of These X-Rays? If "yes", When?

Chest NO YES WHEN _____

Stomach NO YES WHEN _____

Gall Bladder NO YES WHEN _____

Back NO YES WHEN _____

Kidney NO YES WHEN _____

Other NO YES WHEN _____

Have You Ever Had X-Ray Treatment?[Radiation] NO YES WHEN _____

ALLERGIES

Are You Allergic to Any of the Following?

Penicillin NO YES

Sulfa NO YES

Other Antibiotics NO YES

Any Other Drug or Medicine NO YES

Any Food NO YES

Nail Polish or Cosmetic NO YES

Other _____ NO YES

MEDICINES

Are You Taking Any Medicines Regularly Now? NO YES WHAT _____

DIAGNOSED DIFFICULTIES

Do You Now, or Have You in the Past, Had Any of the following:

Migraine Headaches	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Epilepsy or Convulsions	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Stroke	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Glaucoma	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Cataracts	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Blindness Either Eye	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Ear Infections	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Deafness	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Asthma	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Hay Fever	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Chronic Bronchitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Tuberculosis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____

Have you Ever Taken:

Insulin NO YES WHEN _____

Cortisone NO YES WHEN _____

Thyroid Medicine NO YES WHEN _____

Male or Female Hormones NO YES WHEN _____

Blood Pressure Medicine NO YES WHEN _____

Tranquilizers or Sedatives NO YES WHEN _____

Birth Control Pills NO YES WHEN _____

Other NO YES WHEN _____

DEVICES

Do You Use:

Implanted Defibrillator NO YES

Contact Lenses NO YES

I.U.D. NO YES

Dentures NO YES

Pacemaker NO YES

OPERATIONS/Surgeries

Have You Had Any of These Operated Upon:

Tonsils NO YES WHEN _____

Appendix NO YES WHEN _____

Gall Bladder NO YES WHEN _____

Stomach NO YES WHEN _____

Small Intestine NO YES WHEN _____

Kidney NO YES WHEN _____

Colon NO YES WHEN _____

Thyroid NO YES WHEN _____

Hernia (Rupture) NO YES WHEN _____

Angioplasty NO YES WHEN _____

Bypass NO YES WHEN _____

Women

Breast NO YES WHEN _____

Uterus NO YES WHEN _____

Ovaries NO YES WHEN _____

Men

Prostate NO YES WHEN _____

Other[surgery] NO YES WHEN _____

DIAGNOSED DIFFICULTIES (continued)

Abnormal Chest X-Ray	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Heart Murmur as an Adult	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Abnormal Electrocardiogram	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Enlarged Heart	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Heart Attack	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Rheumatic Fever	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Angina	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
High Blood Pressure	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Gall Stones	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Hepatitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Cirrhosis of Liver	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Stomach or Duodenal Ulcer	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Abnormal Stomach X-Ray	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Colon or Bowel Trouble	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Rectal Trouble	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Hemorrhoids or Piles	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Dysentery or Serious Diarrhea	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Kidney or Bladder Infection	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Kidney Stones	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
Other Kidney Diseases	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____

What? _____

Anemia	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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What Kind? _____

Poor Blood Clotting	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Diabetes	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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On Insulin _____

How Much? _____

Gout	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Overactive Thyroid	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Underactive Thyroid	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Goiter	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Broken Bones	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Varicose Veins	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Arthritis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Polio	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Phlebitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Syphilis or V.D.	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Gonorrhea	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Recurrent Boils	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Other Skin Disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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What Kind? _____

Serious Depression	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Serious Emotional Problem	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Nervous Breakdown	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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WOMEN

Menstrual Difficulties	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Ovarian Cyst	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Other Gyn Problems	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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What Kind? _____

Age Periods Started _____				
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Still Menstruating _____	<input type="checkbox"/> NO	<input type="checkbox"/> YES		DATE OF LAST MENSTRUAL PERIOD _____
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Age Periods Stopped _____				
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Why Periods Stopped _____				
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Are Your Periods Regular?	<input type="checkbox"/> NO	<input type="checkbox"/> YES		
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Cystitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Mastitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Breast Cancer	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Other Breast Disease	<input type="checkbox"/> NO	<input type="checkbox"/> YES HAVE NOW	<input type="checkbox"/> YES PAST	WHEN _____
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Number of Times Pregnant _____				
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Number of Children _____ Are You PREGNANT NOW? YES[] NO[] If Yes what is your due date _____

Number of Miscarriages _____

MEN

Prostate Trouble NO YES HAVE NOW YES PAST WHEN _____

Other Illness NO YES HAVE NOW YES PAST WHEN _____

What? _____ NO YES HAVE NOW YES PAST WHEN _____

Coffee No Yes _____Cups/Day

Juice No Yes _____Glasses/Day

De-Caf. No Yes _____Cups/Day

Milk No Yes _____Glasses/Day

Tea No Yes _____Cups/Day

Water No Yes _____Glasses/Day

Herb Tea No Yes _____Cups/Day

Pop/Soda No Yes _____Glasses/Day

Have you had any Accidents or Broken Bones? ____NO ____YES

If yes, please list dates and injuries received.

Please list all prescription medicines or drugs you are now taking, that were prescribed by a doctor or dentist. (Include what you take for chronic conditions, birth control, etc.)

Please indicate strength and number taken daily.

Please list medicines or drugs you sometimes take that were bought without a prescription (such as aspirin, antacids, sleep medicine, allergy, cold medicine, etc.)

Please list all vitamins, minerals and/or nutritional supplements that you are now taking.

Please indicate strength and number taken daily.[USE SEPARATE SHEET if Needed]

Review of Systems – Please fill out all sections even if “NONE”.

Eyes/Vision: None Blindness Blurred Vision Cataracts

Change in Vision Double Vision Eye Pain Tearing

Glasses/Contacts Glaucoma Itching Photophobia

ENT: None Bleeding Dentures Difficulty Swallowing

Discharge Dizziness Ear Drainage Ear Pain/Aches

- History of Head Injury Fainting Headaches Hearing Loss
- Hoarseness Loss of Smell Nasal Congestion Nose Bleeds
- Post Nasal Drip Runny Nose Sinus Infection Snoring
- Ringing in Ears TMJ Stuffy Nose

Respiration: None Cough Coughing up Blood Shortness of Breath
 Sputum Production Wheezing Asthma

Cardio: None Angina Chest Pain Heart Murmur
 Heart Problems Varicose Veins Palpitations Swelling of Legs
 Blood Pressure Problems Stroke

Gastro: None Abdominal Pain Belching Constipation
 Diarrhea Difficulty Swallowing Rectal Bleeding Vomiting Blood
 Vomiting Nausea Jaundice Indigestion
 Hemorrhoids Heartburn Acid Reflux Liver Problems
 Gallbladder Trouble Weight Trouble Poor/Excessive Appetite
 Colitis Gas Bloating

General: None Chills Fatigue Fever
 Night Sweats Weight Gain Weight Loss Allergies
 Loss of Sleep

Endocrine: None Cold Intolerance Diabetes Excessive Appetite
 Goiter Hair Loss Heat Intolerance Unusual Hair Growth
 Excessive Thirst Voice Changes Frequent Urination

3
Female: None Breast Pain/Lumps Burning Urination Cramps
 Frequent Urination Irregular Menstruation Vaginal Bleeding Vaginal Discharge
 When was your last period_____ Are you pregnant? Yes No Not Sure

Male: None Impotence Prostate Problems Burning Urination
 Hesitancy/Dribbling

Skin: None Itching Eczema Psoriasis
 Parathesia Rash Hives Hair Loss
 Hair Growth Changes in Skin Color Changes in Nail Texture

Allergy: None Food Intolerance Itching Nasal Congestion
 Anaphylaxis Sneezing Post Nasal Drip Digestive Trouble

Psychologic: None Anxiety Depression Insomnia
 Memory Loss Behavior Changes Mood Changes Bipolar
 Confusion

Nervous: None Facial Weakness Headache Dizziness
 Limb Weakness Loss of Consciousness Loss of Memory Strokes
 Tremor Seizures Slurred Speech Stress
 Unsteadiness of Gait Tingling Numbness

Marital Status: S M D W Name of Spouse_____

Describe health of spouse_____ Number of children if any_____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Any household pets or other animals you or family members are in close contact with:_____

What can we do to make you happier?_____

SIGNED:_____ DATE_____