Oasis Naturopathic

PATIENT HISTORY

Patient's Name____Birth Date__________Sex_______________

Address ____

Telephone_____________________________

Family History

	Father	Mother	Brother				Sister				Spouse	Children					
			1	2	3	4	1	2	3	4		1	2	3	4	5	6
Age (If Living)																	
Health (G) Good (B) Bad																	
Cancer																	
Tuberculosis																	
Diabetes																	
Heart Trouble																	
High Blood Pressure																	
Stroke																	
Epilepsy																	
Nervous Breakdown																	
Asthma or Allergies																	
Blood Disease																	
Age (At Death)																	
Cause of Death																	

Personal History

Have You Had…	√	Have You Had…	√	Have You Had…	√	Have You Had…	√	Have You Had…	√
Scarlet Fever		Lumbago		High Blood Pressure		Measles		Stroke	
Smallpox		Polio		Low Blood Pressure		Mumps		Hepatitis A/B/C	
Pneumonia		Meningitis		Nervous Breakdown		Chicken Pox		Ulcer	
Pleurisy		Gonorrhea		Hay Fever		Whooping Cough		Kidney Disease	
Undulant Fever		Syphilis		Asthma		Diphtheria		Thyroid Disease	
Rheumatic Fever		AIDS/ HIV		Hives		Heart Disease		Chron's Disease	
Arthritis		Other S.T.D.		Eczema		Bladder Infection		Colitis	
Bone Disease		Anemia		Frequent Colds		Hernia		Irritable Bowel	
Joint Disease		Jaundice		Recurrent Dislocation		Glaucoma		Food Poisoning	
Neuritis		Epilepsy		Concussion		Blood Transfusion		Chemical Poisoning	
Neuralgia		Migraine Headaches		Head Injury		Hemorrhoids		Drug Poisoning	
Bursitis		Tuberculosis		Knocked Unconscious		Bleeding Tendency		Mitral Value Prolapse	
Sciatica		Diabetes		Cancer		Epstein-Barr		Bronchitis	

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PATIENT HISTORY - pg 2

Surgery and Hospitalization				
Have You Had Removed	√	**Have You Had Removed**	√	**List Other Surgeries or Hospitalizations**
Tonsils		Ovaries One or Both		
Appendix		Uterus		
Gall Bladder		Kidney		

Immunization and Medications						
Have You Had…	√	**Have You Had…**	√	**Have You Had…**	√	**List All Medications**
Smallpox Vaccination within 7 years		MMR Shot		Hepatitis B shot		
Tetanus Shot (not Antitoxin)		DPT Shot		Others		
Polio Shots within 2 years		Chickenpox				

Women Only					
Menstrual History		**Menstrual History**	**Y/N**	**Pregnancies**	**#**
Age of Onset	_____Years Old	Are Your periods __ Heavy __ Medium __ Light		# of Children Born Live	
Usual Duration	_____Days	Do You Have __ Tension __ Depression Before Period		# of Cesarean Sections	
Cycle Length	_____Days	Do You Have __ Cramps __ Pain with Period		# of Premature Births	
Irregular periods?	Min___ Max___	Do you have bleeding between periods?		# of Still Born	
Last Pap smear	_______months	Any history of abnormal Pap smears?		# of Miscarriages	
Last breast exam	________months	Do You Have Hot Flashes		Complications? (Y/N)	

Systems					
Constitutional Symptoms	**Y/N**	**Genitourinary**	**Y/N**	**Endocrine**	Y/N
Good General Health Lately		Frequent Urination		Glandular/hormone problems	
Recent Weight Change		Burning/Painful urination		Excessive thirst/urination	
Fever		Blood in urine		Heat/Cold Intolerance	
Fatigue		Change in force/stream during urination		Change in hat/glove size	
Headaches		Incontinence/Dribbling		Dry skin	
Eyes	**Y/N**	Kidney stones		**Hematological/Lymphatic**	**Y/N**
Eye disease or injury		Sexual difficulty		Delayed healing of cuts	
Wear glasses/contacts		Male-penile discharge		Bleeding/Bruise easily	
Blurred or double vision		Male-scrotal pain/inflammation		Blood Clots	
Ears/Nose/Throat/Mouth	**Y/N**	Sexually active		Vein inflammation	
Hearing loss or ringing		Birth Cont/protection_________		Past blood transfusion	
Earaches or drainage		**Musculoskeletal**	**Y/N**	Enlarged glands	
Chronic sinus/rhinitis		Joint pain		**Psychiatric**	**Y/N**
Nose bleeds		Joint stiffness/swelling		Memory Loss/Confusion	
Sore throat/Voice change		Weakness of muscle/joints		Nervousness or Anxiety	
Swollen glands in neck		Muscle pain /cramps		Depression	
Mouth sores		Back pain		Insomnia	
Bleeding gums		Cold Extremities		**Allergic Reactions**	**Y/N**

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PATIENT HISTORY - pg 3

Bad breath		Difficulty in walking		Penicillin/other antibiotics	
Cardiovascular/Pulmonary	**Y/N**	**Integumentary (skin/breast)**	**Y/N**	Morphine/Demerol	
Heart Problems		Rash or itching		Other Narcotics	
Chest pain/Angina Pectoris		Change hair/nails		Novocain/other anesthetics	
Palpitation(flutters)		Change in skin color		Aspirin or anti-inflammatories	
Shortness of breath		Varicose veins		Tetanus antitoxin/other serums	
Walking or lying down		Breast pain		Other drugs/medications	
Swelling of feet/ankles/hands		Breast lump		Known Food Allergies	
High Blood pressure		Breast discharge		Known non-Food Allergies	
Low blood pressure		**Gastrointestinal**	**Y/N**	**Neurological**	**Y/N**
Chronic/Frequent Cough		Loss of appetite		Frequent/Recurring Headaches	
Cough with blood		Change in bowel movements		Lightheaded/dizzy	
TB exposure		Nausea or vomiting		Convulsion/Seizure	
Last chest x-ray_______		Frequent Diarrhea		Numbness or tingling	
Wheezing		Constipation		Tremors(shaking)	
		Abdominal Pain		Paralysis	
		Blood in stool		Head injury	

Habits

Do You…	Y/N	Do You Use…	Never	Occ.	Freq.	Daily
Exercise Adequately, How?		Laxatives				
Sleep Well and Awaken Rested		Vitamins				
Have Regular Bowel Movements		Sedatives				
Have a Satisfactory Sex Life		Tranquilizers				
Like Your Work		Sleeping Pills				
Watch Television (____ Hours per Day)		Aspirins				
Read (____ Hours per Day)		Cortisone				
Take Vacations (____ Weeks per Year)		Alcoholic Beverages				
Have you been treated for Alcoholism		Coffee (___ Cup per Day)				
Have you been treated for Drug Abuse		Cigarettes (___Packs per Day				

Tell me about yourself

What is your favorite color?	What is the ideal climate?
What is your favorite music?	What are your most positive features?
What is your favorite food/drink?	What are your not so positive traits?
What do you like to do the most?	What makes you happy?
What is your ideal job/career?	What makes you sad?
Where is your ideal place to live?	Briefly describe your personality?
What is your favorite plant/flower?	