Dr. Deborah Sellars, ND
Naturopathic Family Medicine

Date_____ Blood Type_____

Name_____ Date of Birth_____

PRESENT HEALTH CARE CONCERNS: In your opinion, what are your most important health care concerns in their order of significance? Please indicate the concern that motivated you to come in today.

1)_____
2)_____
3)_____
4)_____

HEALTH HISTORY: Mark all the sections that apply.

Health as a child? __Good __Fair __Poor

Childhood illnesses?__Scarlet Fever __German Measles __Measles__Pertussis __Mononucleosis __Polio __Diabetes __Rheumatic Fever__Chicken Pox __Diptheria __Mumps__Whooping cough Other_____

Were you breast fed as an infant?__Y__N

Hospitalizations (year & reason)_____

Surgeries (year & type)_____

Serious illnesses or injury (year & cause)_____

Vaccinations (year, type, adverse reactions?) _____

_____

MEDICATIONS : Include all supplements, prescription & non-prescription drugs and indicate name, dosage, how often taken and for how long :

1) _____
2) _____
3) _____
4) _____
5) _____

ALLERGIES: list any allergies you have to:

Drugs _____

Foods _____

Environmental _____

Animals _____

Other _____

What happens when you have an allergy attack? _____

HABITS:

Substance use: For each please include approximate amount and for how long. If you have quit please indicate past amount, duration of usage and when stopped.

Alcohol _____Y_N Tobacco _____Y_N Caffeine _____Y_N Recreational Drugs _____Y_N

Diet: Any dietary restrictions or regimen?

Describe _____

Are you satisfied with your diet now?__ Do you eat three meals daily?__

Do you have any food cravings? What are they? _____

Do you sleep well?__ Wake rested?__ Average hours of sleep? _____

Enjoy your work? __ Spend time outside? __ How much time? _____

Exercise regularly? ___ What type of exercise? _____

How often ? _____ How long? _____

PERSONAL HISTORY: currently (place a C) or in the past (place a P)

Abuse____ Headaches_____ Skin Disease_____

Allergies___ Heart Disease____ Shortness of Breath____

Arthritis___ Hepatitis___ Stomach/Intestinal Disorder____

Back Injury__ Hypertension___ Tested Positive for HIV/Aids____

Chronic Diarrhea__ Physical Trauma___ Thyroid problems___

Sexually -transmitted Infection___ Chronic Constipation___

Depression___ Contemplated Suicide____

Drug/Alcohol Addiction___ Cancer__

For Women:

Age of onset of Menses:_____ Frequency of Menses:_____

Flow: (Circle one) heavy moderate light

Pain with Menses: (circle one) severe moderate none

Date of last period:_____ Date of last Pap Smear:_____

Any history of abnormal Paps: (if yes please specify results, treatments and dates)

_____

Are you sexually active?_____ Do you need help with birth control?_____

Type of Birth Control Method used (if relevant)_____

Do you practice safe sex?_____

Pregnancies: none full term premature miscarriages abortions

Infertility?: if yes any workups, results and dates_____

_____

_____

Vaginal Infections?: current, past and type and symptoms

_____

_____

Any PMS?: if yes timing of symptoms in relation to your menses and symptoms

_____

_____

Any History of DES exposure?:_____

Date of last mammogram and results: _____

Date of Menopause if relevant:_____
Any Problems associated with menopause? _____
_____
_____

FOR MEN:

Date of last physical exam:_____
Date of last Prostate exam:_____ Any problems found?_____
Do you have any difficulty or pain with urination?_____
Do you ever have to get up at night to urinate?: if so, how often?_____
Are you sexually active?:_____ Do you practice safe sex?_____
Do you have any pain or difficulty with erection ?:_____ ejaculation?:_____
Any history of male infertility?: (if yes please give diagnosis and treatments tried)_____
_____
_____

CHILDREN:

Pregnancy and Birth Experience:

term____ preterm_____If preterm, how many weeks/days_____
illness during pregnancy_____
personal stress during pregnancy_____
prescription drugs or recreational taken during pregnancy_____
smoker_____
exposure to chemicals_____
vaginal vacuum extraction____vaginal forceps delivery_____
c-section____Vaginal birth after c-section_____
APGAR scores_____Birth weight_____ Birth Height_____
length of delivery_____birth injuries____
maternal problems at birth_____
medicine given during labor_____
Did baby need any extra care at birth or prior to going home?_____

Infant feeding under 6 months:

breast milk____ how long?_____problems?_____
supplemented breast milk with_____
If formula what kind?_____how long?_____
Problems while on formula?_____
first foods at____months, name foods_____
any problems?_____

Childhood trauma:

Injuries_____
surgery_____
frights_____
other_____

Sleep patterns

number of hours per night_____wakes up_____ times per night

nightmares_____sleep walks or talks_____bed wetting after potty trained____

Family situation

divorce____death_____ step parent____new siblings_____

How many siblings_____ what are their ages_____

Family History: Has any blood relative (mother (M), father (F), brother (B), sister (S), grandmother (GM), grandfather (GF), aunt (A), uncle (U) had any of the following conditions, in the past or present?

Condition	Relative	Condition	Relative	Condition	Relative
Anemia	_____	Arthritis	_____	Asthma	_____
Bleeding	_____	Osteoporosis	_____	Constipation	_____
Diabetes	_____	Eczema	_____	Glaucoma	_____

Herpes_____ Allergies _____ Headaches _____

Heart problem_____Hypertension_____ Kidney problems_____

Liver problem_____ Seizure _____ Mental disorder_____

Stroke _____ Sinus problems_____ Stomach problem_____

Tuberculosis_____ Thyroid Disease_____ Venereal disease _____

Drug or alcohol addiction_____

Genetic disease_____

Cancer (specify type)_____

Other_____

_____

RELATIVE **HEALTH STATUS** **AGE** **IF DECEASED** cause of & age at death

FATHER_____

MOTHER_____

SIBLINGS_____

_____