

NATURAL MEDICAL CARE

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I. Patient Information

Patient Name (Last, First, Middle Initial) _____

Parent or Legal Guardian (if a minor) _____

Address _____

Birth date _____ Patient SS # _____

Sex: M or F Single__ Married __ Widowed __ Separated __ Divorced __

Home Phone _____ Work Phone _____ Ext. ____ Mobile _____

When is the best time to reach you? _____ Email Address _____

Occupation _____ Employer/School _____

Employer/School Address _____

Email Address _____

Whom may we thank for referring you? _____

II. Spousal Information

Spouse Name _____

Spouse Birth date _____ Spouse SS # _____

Spouse Occupation _____ Spouse Employer _____

III. In Case of Emergency

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Mobile _____

IV. Responsible Party

Who is responsible for this account (if other than patient)? _____

Relationship to Patient _____ Responsible Party SS# _____

Responsible Party Home Phone _____ Work Phone _____ Ext _____

I understand that I am financially responsible for all charges

Responsible Party Signature/Date

V. Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following:

Check	Disease	Relationship	Check	Disease	Relationship
	Arthritis, Gout			Asthma, Hay Fever	
	Cancer			Chemical Dependency	
	Diabetes			Heart Disease, Strokes	
	High Blood Pressure			Kidney Disease	
	Tuberculosis			Other	

VI. Medical History

What is the reason for your visit today?

Check the symptoms you currently have or have had in the past year:

GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of Weight
- Numbness
- Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

GENITO-URINARY

- Blood in Urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTRONINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest Pain
- High/Low Blood Pressure
- Irregular/Rapid heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache/Ear discharge
- Hay fever
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - flashes/halos

SKIN

- Bruise easily
- Hives
- Itching/Rash
- Change in moles
- Scar
- Sore that won't heal

MEN ONLY

- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

WOMEN ONLY

- Abnormal Pap Smear
- Bleeding between periods
- Breast Lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful Intercourse
- Vaginal discharge
- Other
- Date of last period _____
- Date of last Pap _____
- Have you had a mammogram? _____
- Are you pregnant? _____
- Number of children _____

Check (✓) conditions you currently have and mark (X) conditions you have had in the past

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |

VII. Medication and Allergies

List medications you are currently taking:

Pharmacy Name _____ Pharmacy Number _____

List allergies to medications or substances:

VIII. Health Habits

Health Habits: Check which substances you use and describe how much you use:

- Caffeine _____
- Drugs _____
- Tobacco _____
- Other _____

Occupational: Check if your work exposes you to the following:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other _____

IX. Signatures

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed By _____ Date _____