Adult Medical History/Information Forms

Today's Date: _____

Name: _____ Age: _____ Birthdate: _____

Astrology: Sun: _____ Ascendant: _____ Moon: _____

Current Height: _____ Weight: _____ Eye color: _____Hair color: _____

Occupation: _____ Hobbies/Interests: _____

Address: _____

Telephone: _____ email: _____

Primary Care Physician: _____ Telephone: _____

Current medications/mg/dosage: _____

ALLERGIES: _____

* *

Any known details of your conception, gestation and birth: _____

_____ Birthdate: _____ City/State: _____Time: _____

Details and length of labor: _____

Type of delivery: _____ Home? _____ Hospital? _____

Medications/Epidural? _____

Full Term? _____ Premature? _____ Condition at birth/Apgar score: _____

Length at birth: _____ Weight at birth: _____ Other: _____

Vaccinations:

MMR Date(s): _____ Reactions: _____

DPT Date(s): _____ Reactions: _____

HIB Date(s): _____ Reactions: _____

Hep B Date(s): _____ Reactions: _____

Chicken Pox Date(s): _____ Reactions: _____

Other _____Date(s): _____ Reactions: _____

Record of Illnesses:

Measles Date/Age: _____ Symptoms and treatments: _____

_____

Mumps Date/Age: _____ Symptoms and treatments: _____

_____

Chicken Pox Date/Age: _____ Symptoms and treatments: _____

_____

Colds/ Earaches Dates/Age: _____ Symptoms and treatments: _____

_____

Sore Throats/ Tonsillitis Dates/Age: _____ Symptoms and treatments: _____

_____

Asthma Dates/Age: _____ Symptoms and treatments: _____

_____ Hospitalized? _____

Bronchitis/ Pneumonia Dates/Age: _____ Symptoms and treatments: _____

_____ Hospitalized? _____

Viruses/Flu Dates/Age: _____ Symptoms and treatments: _____

_____

Sexually Transmitted Diseases: _____

Accidents/Injuries/Fractures/Surgeries:

Date/Age: _____ Details: _____

Treatments/Hospitalization: _____

Date/Age: _____ Details: _____

Treatments/Hospitalization: _____

Date/Age: _____ Details: _____

Treatments/Hospitalization: _____

FAMILY HISTORY: [e.g., MGM = Maternal Grandmother; PGGF = Paternal Great Grandfather, etc.]

Problem/Disease | Family Member | Details | Age First Acquired | Age of Death

Anemia/Clotting Disorders: _____

Diabetes: _____

Heart Attack/Stroke: _____

High BP/High Cholesterol: _____

Tuberculosis: _____

Cancers: _____

_____

Addictions: _____

Mental Illness: _____

Sexually Transmitted Diseases: _____

Other: _____

Describe your overall personality: _____

_____

Anger – what causes it? _____ How do you show anger? _____

_____

Major grief/losses in life: _____ and how have you

reacted: _____

3 worst fears and your responses to fear: _____

_____

Food & Drink:

Cravings/Favorites: _____

Aversions: _____

Sensitivities/Allergies: _____

Thirsty for water: _____ Quantity: _____ Cold/Iced: _____ Room temp.: _____ Don't drink water much: _____

Usually drink (type of juice, soda, etc.) _____

I am usually warm and don't wear a lot of clothes/blankets: _____

I am usually cold and like to bundle up: _____

Affects of COLD: (weather, wet, food/drink): _____

Affects of HEAT: (weather, sun, food/drink): _____

Favorite Season(s): _____ and type of weather: _____

Urinary Habits: Frequency: _____ Color: _____ Odor: _____

Problems/History: _____

Bowel Habits: Frequency: _____ Color: _____ Odor: _____

Problems/History: _____

Menstrual Cycle: # days between: _____ Lasting _____days. Color/clotting: _____

Cramping: _____ Treatment(s): _____

Headaches: Frequency: _____ Sensations: _____

When/how do they begin? _____

What makes it worse? _____

What makes it better? _____

Treatments/Medications: _____

Skin Problems: Type: _____ Where on body: _____

Coloration: _____ Discharge: _____ Odor: _____

When/how did it begin? _____

Any Family History of similar skin problems/details: _____

Style of Interpersonal Relationships: (describe yourself, such as: open/closed, extrovert/introvert, tense/relaxed, structured/spontaneous, reactive/easy-going, social/awkward in groups/public, etc.) _____

_____I live: alone_____ with a partner_____ with roommates _____ other _____

Sensuality/Sexuality: (describe yourself, such as flirtatious/shy, sensual/sexual, comfortable/uncomfortable with touch/ intimacy/sexuality, high/low libido, gently/intensely sexual, hetero/homo/bi/trans-sexual, daring and/or S & M, etc. single/ married/living together/newly dating, etc.)

_____

_____

Spirituality/Religion/Church: _____ Since: _____

Specific Practices: _____

Sleep: Bedtime: _____ # hours: _____ Body Position: _____

Restless? ___ Deep sleeper? ___ Easily awakened? ___ Well rested upon waking? ___ Other: _____

Dreams: Remembered? _____ Recurrent themes: _____

In color? _____ Details: _____

Childhood nightmaress? _____ Details/recurrent themes: _____

Any specific Dream since making this appointment? _____

_____

Nutrition and Exercise:

I follow a (vegan/vegetarian/carnivorous/_____) diet since _____.

I eat _____meals & _____ snacks per day = to approximately _____ calories.

Herbs/supplements (brand, type, milligrams, dosage): _____

_____

_____

Details of most recent cleanse/fast: _____

_____

My typical exercise routine: _____

_____

What are the main reasons you are seeking Naturopathic/Homeopathic care? _____

_____

_____[use another page as necessary]

Anything else you would like me to be aware of? _____

_____[use another page as necessary]]