



SOUND NATURAL MEDICINE

284 Central Way - Kirkland, WA 98033

Medical History

Name: _____ Birthdate: _____ Age: _____
(Last) (First)

Reason for your visit:

REVIEW OF SYSTEMS

Have you had or do you now have any of the following: (please check each item):

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| YES | No | 1. General | YES | NO | 8. Genitourinary (Continued) |
| <input type="checkbox"/> | <input type="checkbox"/> | My health is generally good | <input type="checkbox"/> | <input type="checkbox"/> | Pelvic infection/Pain/PID |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent weight gain or loss (> 25 lbs) | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent vaginal infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent colds, flu, ext. | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease:
Chlamydia/Gonorrhea/Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic fatigue (> 6 months) | | | Syphilis/Genital Warts/Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____ | | | Breast problems: Discharge/
Disease/Tumor/Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Genetic Condition | <input type="checkbox"/> | <input type="checkbox"/> | Do you check your breasts?
Results _____ |
| | | 2. Immunizations | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal pap smear
Dates _____
Treatment _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B | | | 9. Hematologic |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaccine/shot for Rubella/MM | <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetanus Vaccine shot | <input type="checkbox"/> | <input type="checkbox"/> | Blood clotting disorder |
| | | 3. Cardiovascular | <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease/Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia/Trait/Thalassemia/PKU |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Cholesterol/Triglycerides | | | 10. Skin |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Acne |
| <input type="checkbox"/> | <input type="checkbox"/> | Thrombophlebitis/Blood Clots | <input type="checkbox"/> | <input type="checkbox"/> | Chronic rash/itching |
| <input type="checkbox"/> | <input type="checkbox"/> | In veins or lungs | <input type="checkbox"/> | <input type="checkbox"/> | Other skin problems |
| | | 4. Neurologic | | | 11. Musculoskeletal |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraine | <input type="checkbox"/> | <input type="checkbox"/> | Broken bones/fractures |
| <input type="checkbox"/> | <input type="checkbox"/> | Sensory difficulties (numbness, hearing,
taste, smell) | <input type="checkbox"/> | <input type="checkbox"/> | 12. Eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual changes (blurring, spots,
lines in front of eyes) | <input type="checkbox"/> | <input type="checkbox"/> | Eye problems (other than glasses) |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures/Epilepsy | | | 13. Ears, Nose, Throat, Mouth |
| | | 5. Gastrointestinal | <input type="checkbox"/> | <input type="checkbox"/> | Hearing problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach/bowel problems | <input type="checkbox"/> | <input type="checkbox"/> | Teeth/Gum problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease/jaundice | | | 14. Psychology |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder disease | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| | | 6. Endocrine | <input type="checkbox"/> | <input type="checkbox"/> | Severe mood swings |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes/Diabetes of pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | Under care of Psychiatrist/Psychologist |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems | | | |
| | | 7. Respiratory | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other breathing problems | | | |
| | | 8. Genitourinary | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent bladder infections (> 3 per year) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder, urinary or kidney problems | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormality of uterus | | | |

SEE REVERSE

MENSTRUAL HISTORY (Females)

Date your last normal period started _____

Age periods started _____

How often do you get your period? _____

Number of days of flow _____

YES NO

- Was your last menstrual period normal?
 Have you had intercourse since your last period?
 Are you concerned that you could be pregnant now?
 Severe cramps?
 Missed periods?
 Bleeding between periods?

Please describe any problems you have with your periods NOW:

PREGNANCY HISTORY (Females) Never Pregnant (Skip to next section)Do you think you are pregnant now? Yes No

Age at first pregnancy: _____ Total pregnancies: _____

of living children: _____

Abortions _____ Dates: _____

Miscarriages _____

Still births _____

Cesarean births _____

Vaginal births _____

Ectopic pregnancies (tubal) _____

Premature births _____

Genetic abnormalities _____

Gestational diabetes _____

Toxemia of pregnancy _____

Are you breastfeeding now? Yes No**SOCIAL/HEALTH RISK HISTORY**

YES NO

- Do you smoke? How many cigarettes a day? _____
 Do you use alcohol? If yes, how often/how much? _____
 Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?
 Do you or your partners use street or IV (injectable) drugs?
 Do you or your partners share needles of any kind?
 Have you ever had or would you like help now with an alcohol or drug abuse problem?
 Are you now or have you ever been in a relationship where you have been physically or emotionally hurt or threatened?
 Do you feel safe at home?
 Do you know where you could go or who could help you if you were abused or worried about abuse?
 Do you wear a seat belt?

Please list any **ALLERGIES**, including drugs, metal, skin allergies or irritants, or rubber/latex sensitivity: _____

Please list any medications (over-the-counter or prescription) or supplements (vitamins, herbs, etc) you currently take:

FAMILY HISTORY (If you are adopted, check and skip to the next section.)

Anyone in your immediate family ever had the following? If yes indicate father (F), mother (M), brother (B), or sister (S)

___ No longer living (Age/Cause of death (_____, _____))

___ Breast, Ovarian or Uterine Cancer (Age at onset: _____)

___ Heart Attack/Heart Disease/Surgery (Age at onset: _____) ___ Other Cancer

___ High Blood Cholesterol/High Blood Pressure ___ Diabetes Yes NoWomen born 1940-1970: Did your mother take DES (hormones) during her pregnancy with you? Yes No**MEDICAL HISTORY**

YES NO

- Have you ever had surgery or been a patient in a hospital?
 If yes, describe: _____
 Are you now, or have you been, under a doctor's care for a serious illness or condition?
 If yes, describe: _____
 Do you have another source of health care? Where? _____

TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.

Patient Signature _____ Date of Birth _____ Date _____