HUDSON
NATUROPATHIC CLINIC

CONFIDENTIAL PATIENT HEALTH RECORD

Current Health Condition:

What are your goals for this visit?

_____
_____
_____
_____

Prioritize your most important health concerns today:

	Concern	Onset	Frequency	Severity
	Ex. Painful hip joint	Nov. 1990	3x/week	mild/mod/severe
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

What, if any, treatments have you tried?

_____
_____

Are you currently being treated by a physician? Yes/No (*circle*)
Physician name: _____ Condition:_____

What prior experiences have you had with alternative or complementary medicine?

_____
_____

Personal Medical History:

Please check the boxes as applicable.

Illness	Current	Past	Never	Illness	Current	Past	Never
Example	✓			Heart Disease			
AIDS				Heart Murmur			
Allergies				Hemorrhoids			
ADD/ADHD				Hepatitis			
Alcoholism				Herpes			
Altered sense (e.g. taste, smell)				High Cholesterol			
Anemia				High Blood Pressure			
Anxiety/Panic Attacks				HIV			
Appendicitis				Hyperthyroid			
Arthritis				Hypothyroid			
Asthma				Injury (serious)			
Bleeding Difficulties (ex. Hemophilia, hypercoagulation)				Kidney Disease			

Blood in stool				Liver Disease/Jaundice			
Blurred Vision				Low Blood Sugar			
Breast Lump				Measles			
Cancer				Migraine Headaches			
Candida (yeast) Infection				Multiple Sclerosis			
Cataracts				Numbness/Tingling			
Chemical Dependency				Obesity			
Chemical Sensitivities				Ovarian Cysts			
Chicken Pox				Pacemaker			
Chronic Fatigue				Pneumonia			
Colitis				Post Traumatic Stress Disorder			
Depression				Prostate Problem			
Diabetes				Recreational Drug Use			
Dizziness/Vertigo				Rheumatic Fever			
Eczema				Rheumatoid Arthritis			
Emphysema				Scarlet Fever			
Epilepsy				Schizophrenia			
Fainting				Seizure/Epilepsy			
Fibromyalgia				Stroke			
Genital Herpes				Syphilis			
Gastrointestinal Ulcers				Tuberculosis (TB)			
Glaucoma				Ulcers			
Gout				Venereal Disease			
Headaches				Other:			

Medications and Allergies:

What **medications** are you taking now (include prescription and over-the-counter drugs)?

Medication	**Reason**	**When Started**	**Dosage Per Day**

What **vitamins/minerals/herbal supplements, etc** are you taking now?

Supplement + Brand	Reason	When Started	Dosage Per Day

Allergies to medicines or substances:

_____

_____

Please describe reaction: _____

_____

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
	Alcoholism			Gout	
	Alzheimer's Disease			Hay Fever	
	Arthritis			Heart Disease	
	Asthma, Allergies, Hives			High Blood Pressure	
	Autoimmune Disease			HIV/AIDS	
	Cancer			Kidney Disease	
	Chemical Dependency			Mental Illness	
	Depression			Strokes	
	Diabetes			Obesity	
	Epilepsy			Parkinson's Disease	
	Gastrointestinal Disease			Suicide	
	Glaucoma			Tuberculosis	

Psychological/Social History:

What are the major stressors in your life?

_____

_____

What do you do to relieve stress? What interests/hobbies do you have?

_____

_____

_____

How would you describe your average mood? i.e. happy, sad, depressed, energized?

_____

_____

Do you have friend and/or family support in your life? _____

_____

Spiritual beliefs/religious affiliations:

_____

_____

Health Habits:

What physical activity do you participate in, and how often?

_____

Energy level? _____

Describe your sleep pattern (i.e.hours/night, wake rested): _____

_____

Tobacco use: *note current or past use*
Type: _____ Amount per day (or week): _____
Recreational drugs: *note current or past use*
Type: _____ Amount per day (or week/month): _____
Alcohol: *note current or past use*
Type: _____ Amount per day (or week/month): _____

Have you ever had to cut down on your drinking? Yes/No (*circle*)
Do you get annoyed when someone asks about your drinking? Yes/No (*circle*)
Do you ever feel guilty about your drinking? Yes/No (*circle*)
Do you ever have to make excuses for drinking or for your behavior while drinking? Yes/No (*circle*)

Are you familiar with safe sex practice? Yes/No

Nutrition:

How many meals do you generally eat per day? _____ Do you skip meals? _____
Please describe what you eat on average for breakfast: _____
Average lunch: _____
Average dinner: _____

Snacks: _____
What are your sources of protein? _____
What and how much do you drink on a typical day (i.e. water, soda, caffeinated drinks)?
_____

Are you currently on a special diet? Food allergies? Foods you avoid? Vegetarian? Please explain.
_____
_____

How often do you eat out? _____
Who prepares the meals at home? _____

Review of Systems:
Please circle what applies and describe extra details.

General: fatigue, low energy, chills, fever, more thirsty than normal, unusual weight gain or loss, excessive perspiration, night sweats, prefer warm/cold/both equally (*circle*), other
_____

Skin: change in color or size of moles, cuts that don't heal, easy bruising, cellulite, varicose veins, rashes, unusually dry skin, other
_____

Nails: cracking, too soft, thin, ridges, white spots, other
_____

Head: acne, fainting, dizziness, loss of hair, numbness in face or jaw, other
_____

Eyes: eye pain, blurry vision, visual changes, spots, floaters, itchy eyes, glasses, other
_____

Ears: difficulty hearing, ear ringing or buzzing, earaches/discharge from ears (*circle*), excessive wax in ears, other
_____

Nose: excessive nasal stuffiness/sinusitis, drainage down back of throat, frequent or severe nosebleeds, other
_____

Mouth: mercury fillings, bad breath, bleeding gums, sore tongue, excessive saliva, other
_____

Throat: lump(s) in throat, swallowing problems, soreness in throat, other
_____

Respiratory System: frequent chest colds, constant or bothersome cough, blood in phlegm (when coughing), phlegm between colds, difficulty breathing, wheezing or whistling from chest, shortness of breath, other
_____

Cardiovascular System: high blood pressure, irregular heart rhythms, skipped beats, chest pain, abnormal EKG, swelling of feet or ankles, fingers/toes get cold/numb/blue (*circle*), other

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Gastrointestinal System: bloating, gas, heartburn, nausea, vomiting, cramping, reflux, blood in vomit, constipation, diarrhea, blood in stool, hemorrhoids, poor appetite or easily satiated, other

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Lymph Nodes: swollen, painful, other

Musculoskeletal System: pain in your legs or feet, regular pain anywhere else in body, diagnosed scoliosis, joint pain or stiffness, arthritis, other

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Urogenital: burning or pain on urination, change in frequency of urination, urinary incontinence, urge to urinate at night, problem dribbling urine, blood in urine, frequent bladder or kidney infections, men: prostrate trouble or erectile dysfunction, other

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Central Nervous System: lost consciousness, generally a nervous person, trouble remembering recent events, convulsions or fits, insomnia, highly emotional, other

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Psychological/Mental Status: depression, anxiety or panic attacks, diagnosed with a psychological condition, suicidal thoughts, suicidal attempts, excessive restlessness, mental confusion, critical of yourself or others, mood swings, loneliness, other

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Environmental Exposure: significant exposure to toxic chemicals/solvents/oil paints, excessive exposure to toxic fumes (i.e. gasoline, exhaust fumes, burning of toxic materials), other

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Miscellaneous:
Treated for parasitic/bacterial/viral infections (*circle*)?
How often have you taken antibiotics? Infancy/childhood ___ Teen ___ Adulthood ___ # of times
Extended time spent in a foreign country? Yes/No. If yes, please list countries:

Typical childhood vaccinations? Yes/No Received regular booster shots to date? Yes/No

Women Only: Gynecology and Pregnancy

Age at first menstrual period: ____ Onset of most recent menstrual period: _____ (mm/dd/yr)
Duration of flow: _____ days. Time between cycles: _____days. Regular/Irregular cycles (*circle*)
Flow (*circle*): excessive/moderate/scanty
PMS? Yes/No If Yes, symptoms? (i.e. severe cramps, moderate insomnia, mild depression)
_____

If applicable: Age at menopause: _____ Menopausal symptoms: _____
Have you ever had any post-menopausal bleeding? Yes/No

Please specify the number of births: _____ miscarriages: _____ abortions: _____
Have you experienced complications during pregnancy/delivery/other problems?
_____

Method of birth control_____
I will alert Dr. Hudson if I know or suspect that I am pregnant while under her care: _____(initial)

Date of last PAP:_____(mm/dd/yr) History of abnormal PAPs? Yes/No

Check if applicable:

__Breast lumps	__Pain during orgasm	__Pass clots with periods
__Breast tenderness	__Abnormal vaginal discharge	__Past or current use of IUD
__History of genital warts	__Vaginal dryness	__Perform self-breast exams
__Mother or sister with breast cancer	__Vaginal itching	__Spotting between periods
__Nipple discharge	__Vulvar itching	__Infertility problems
__Pain during intercourse	__Water retention	

Please feel free to use the remaining space to discuss anything else you wish me to know about your life, health, emotions, the kind of person you are, goals, concerns, etc.

_____
_____
_____
_____
_____

Signature:

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

Signature _____ Date _____