



Name: _____ **Date:** _____

Y = Condition you have now **P** = Condition you had in the past **skip** if you've never had it

1. GENERAL		
Current Weight:	Current Height:	
Weight 1 year ago:	Maximum weight (non-pregnant):	When?

2. SKIN					
Rashes	Y	P	Lumps	Y	P
Eczema, hives	Y	P	Dryness/Moistness	Y	P
Acne, boils	Y	P	Nail changes	Y	P
Itching	Y	P	Change in Mole	Y	P
Color changes	Y	P	Skin Cancer	Y	P
Comments:					

3. HEAD					
Headache	Y	P	Dizziness	Y	P
Head injury	Y	P			
Comments:					

4. EYES					
Impaired vision	Y	P	Cataracts	Y	P
Glasses/Contacts	Y	P	Bothered by sun	Y	P
Eye pain	Y	P	Itching	Y	P
Tearing or dryness	Y	P	Redness	Y	P
Double vision	Y	P	Discharge	Y	P
Glaucoma	Y	P	Blind spot	Y	P
Comments:					

5. EARS					
Impaired hearing	Y	P	Discharge	Y	P
Earache	Y	P	Infections	Y	P
Dizziness	Y	P			
Comments:					

6. NOSE and SINUSES					
Frequent colds	Y	P	Hay fever	Y	P
Nose bleeds	Y	P	Sinus problems	Y	P
Stuffiness	Y	P			
Comments:					



7. MOUTH and THROAT

Frequent sore throat	Y	P	Hoarseness	Y	P
Sore tongue/mouth	Y	P	Dental cavities	Y	P
Gum problems	Y	P	Loss of taste	Y	P
Comments:					

8. NECK

Lumps	Y	P	Goiter	Y	P
Swollen glands	Y	P	Pain or stiffness	Y	P
Comments:					

9. RESPIRATORY

Cough	Y	P	Emphysema	Y	P
Sputum	Y	P	Difficulty breathing	Y	P
Spitting up blood	Y	P	Pain on breathing	Y	P
Wheezing	Y	P	Shortness of breath	Y	P
Asthma	Y	P	Shortness of breath at night	Y	P
Bronchitis	Y	P	Shortness of breath lying down	Y	P
Pneumonia	Y	P	Tuberculosis	Y	P
Pleurisy	Y	P	Tuberculin Test	Y	P
Comments:			Date of Last Chest x-ray:		

10. CARDIOVASCULAR

Heart disease	Y	P	Chest pain	Y	P
Angina	Y	P	Swelling in ankles	Y	P
High blood pressure	Y	P	Palpitations, fluttering	Y	P
Murmurs	Y	P	Cyanosis	Y	P
Past ECG & Date	Y	P	Rheumatic fever	Y	P
Other heart tests & Comments:					

11. PERIPHERAL VASCULAR

Deep leg pain	Y	P	Extremity numbness	Y	P
Cold hands/feet	Y	P	Extremity coldness	Y	P
Varicose veins	Y	P	Extremity swelling	Y	P
Thrombophlebitis	Y	P	Extremity ulcers	Y	P
Leg cramps	Y	P			
Comments:					

12. BLOOD/LYMPHATIC

Anemia	Y	P	Past transfusions	Y	P
Easy bleeding or bruising	Y	P	Lymph node swelling	Y	P
Comments:					

Review of Systems

13. GASTROINTESTINAL					
Trouble swallowing	Y	P	Belching or passing gas	Y	P
Heartburn	Y	P	Food allergy	Y	P
Change in thirst	Y	P	Indigestion	Y	P
Change in appetite	Y	P	Ulcer	Y	P
Nausea	Y	P	Blood in stool	Y	P
Vomiting	Y	P	Rectal bleeding	Y	P
Vomiting blood	Y	P	Hemorrhoids	Y	P
Hernias	Y	P	Black, tarry stool	Y	P
Jaundice (yellow skin)	Y	P	Diarrhea	Y	P
Liver disease	Y	P	Abdominal pain	Y	P
Gall Bladder disease	Y	P	Bowel movements (per day & per week)		
Comments:			Is this a change?	Y	N

14. URINARY					
Pain on urination	Y	P	Kidney stones	Y	P
Increased frequency	Y	P	Blood in urine	Y	P
Frequency at night	Y	P	Urgency	Y	P
Frequent infections	Y	P	Hesitancy	Y	P
Comments:			Inability to hold urine	Y	P

15. MALE REPRODUCTIVE					
Hernias	Y	P	Sexual difficulties	Y	P
Testicular masses	Y	P	Venereal disease	Y	P
Testicular pain	Y	P	Discharge or sores	Y	P
Are you sexually active?	Y	P			
Comments:					

16. FEMALE REPRODUCTIVE					
Age menses began			Number of pregnancies		
Average number of days of bleeding			Number of live births		
Length of cycle			Number of miscarriages		
Last menstrual period			Number of abortions		
Bleeding between periods	Y	P	Painful menses	Y	P
Are cycles regular	Y	P	Excessive flow	Y	P
Pain during intercourse	Y	P	PMS	Y	P
Difficulty conceiving	Y	P	Vaginal discharge	Y	P
Sexual difficulties	Y	P	Vaginal itching	Y	P
Venereal Disease	Y	P	Last PAP - (date)		
Are you sexually active?	Y	N	Type of birth control?		
Do you do self- breast exams regularly?	Y	P	Breast pain (or tenderness)	Y	P
Breast lumps	Y	P	Nipple discharge	Y	P
Comments:					

17. MUSCULOSKELETAL

Joint pain or stiffness	Y	P	Weakness	Y	P
Arthritis	Y	P	Joint swelling	Y	P
Broken bones	Y	P	Backache	Y	P
Muscle spasms or cramps	Y	P			
Comments:					

18. NEUROLOGIC

Fainting	Y	P	Loss of memory	Y	P
Seizures/Convulsions	Y	P	Involuntary movement	Y	P
Paralysis	Y	P	Loss of balance	Y	P
Muscle weakness	Y	P	Speech problems	Y	P
Numbness or tingling	Y	P			
Comments:					

19. ENDOCRINE

Heat or cold intolerance	Y	P	Excessive sweating	Y	P
Thyroid trouble	Y	P	Diabetes	Y	P
Excessive thirst	Y	P	Hypoglycemia	Y	P
Excessive hunger	Y	P	Hormone therapy	Y	P
Excessive urination	Y	P			
Comments:					

20. ALLERGIC HISTORY

Drug sensitivity	Y	P	Reaction to vaccine	Y	P
Other Allergies? Please list.					

21. EMOTIONAL

Depression	Y	P	Phobias	Y	P
Mood swings	Y	P	Alcohol/Drug abuse	Y	P
Anxiety or nervousness	Y	P	Insomnia	Y	P
Tension	Y	P			
Comments:					

22. HOBBIES/HABITS

Do you eat three meals daily?	Y	N	Do you take vacations?	Y	N
Do you awake rested?	Y	N	Do you enjoy your work?	Y	N
Do you sleep well?	Y	N	Do you read?	Y	N
Do you average 6-8 hours sleep?	Y	N	How often do you exercise?		
Do you use recreational drugs?	Y	N	Do you drink alcohol?	Y	N
# of times treated for drug dependence:			# of times treated for alcoholism:		
What are your main interests and hobbies?			How much TV do you watch?		



Vanessa Lee BSc, ND
Naturopathic Doctor

Name: _____ **Start Date:** _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Lunch							
Dinner							
Snacks & Fluid Intake							
How do you feel today? (Mentally, Physically & Emotionally)							

