Rockwood Natural Medicine Clinic

9755 N. 90th St., Suite A-210 Scottsdale, Arizona 85258 480-767-7119

Date:

Name: Age: Sex: M F

Are you: Married Separated Divorced Widowed Single

How did you hear about our clinic?

When did you have your last health care visit?

What was the reason?

Please list in order of importance your health problems:

1.
2.
3.
4.
5.

Family History Y = yes N = no P = past

Has any family member had the following:				If yes, please identify family member:
Anemia				
Asthma				
Cancer				
Diabetes				
Epilepsy				
Glaucoma				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Mental Illness				
Pneumonia				
Stroke				
Tuberculosis				
Venereal Disease				

Were any of these a cause of death? If so, which family member and at what age?

Childhood Illnesses:

Scarlet Fever			Diphtheria			Rheumatic fever		
Mumps			Measles			German measles		

Immunizations:

Polio
Measles/Mumps
Pneumonia
Tetanus

Diphtheria
Pertussis
Small pox
Date of last tetanus shot: _____

Rubella
Hepatitis B
Anthrax

Allergies:

What drugs are you allergic to? _____

What foods? _____

Environmental allergies? _____

Have you ever been hospitalized? If yes, when and for what reason: _____

Have you had any surgeries? If yes, when and for what reason: _____

Current Medications:

Appetite suppressants
Tobacco
Pain relievers
Birth control pills
Thyroid

Laxatives
Antacids
Tranquilizers
Sleeping pills
Cortisone

Please list any prescription medications, over-the-counter medicines, vitamins or other supplements you are currently taking: _____

Skin

Acne
Color Changes
Hives
Lumps
Rashes

Boils
Eczema
Itching
Moles
Scaling

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Head

Hair loss
Head injury

Headaches
Skull fracture

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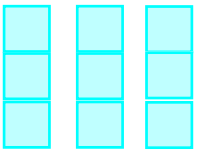
Eyes

Eye pain
Double vision
Vision aids
Impaired vision

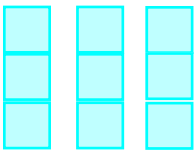
Cataracts
Dryness
Glaucoma
Tearing

Ears

Discharges
Dizziness
Ringing



Earaches
Impaired hearing
Trauma to ear



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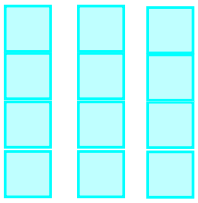
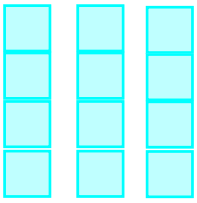
Nose & Sinuses

Frequent colds
Nose bleeds
Stuffiness
Trauma to nose



Hay fever
Sinus pain
Persistent running
Polyps



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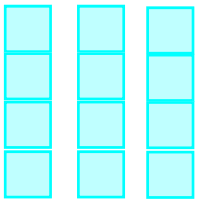
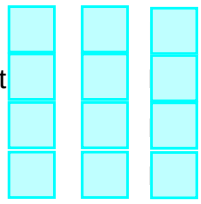
Mouth & Throat

Bleeding gums
Cavities
Hoarseness
Ulcerations



Difficulty swallowing
Frequent sore throat
Sore tongue
Difficulty speaking



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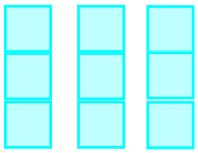
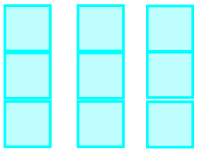
Neck

Goiter
Pain or stiffness
Trauma to neck



Lumps
Swollen glands
Thyroid medication



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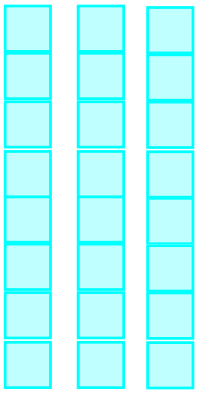
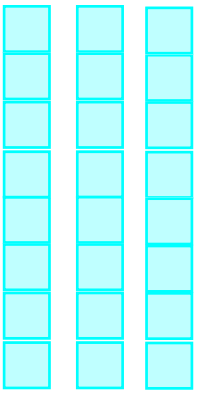
Respiratory

Asthma
Cough
Pleurisy
Pneumonia
Sputum
Tuberculosis
Wheezing
Blood in sputum



Bronchitis
Emphysema
Difficulty breathing
Pain with breathing
Shortness of breath
with lying down
with exertion
at night



Cardiovascular

Angina
High blood pressure
Heart disease
Palpitations/fluttering
Rheumatic fever

Chest pain
Dizziness
Murmurs
Leg pain with walkin
Ankle swelling

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Gastrointestinal

Belching
Change in appetite
Gallbladder disease
Gas/bloating
Liver disease
Vomiting
Ulcers

Blood in stool
Change in thirst`
Heartburn
Hemorrhoids
Jaundice/yellow skin
vomiting of blood
Bowel movements:
How often:
Is this a change:

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Urinary

Frequent infections
Increased frequency
Kidney stones
Pain with urination

Frequency at night
Inability to hold urine
Kidney pain
Urethral discharge

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Endocrine / Blood

Anemia
Easy to bleed/bruise
Excessive hunger

Excessive thirst
Heat/cold intolerance
Low energy/fatigue

Female Reproductive System

Age menses began:
Average number of days:
Length of cycle:
Are cycles regular
Do you have:
Painful menses:
Pain with intercourse
Excessive flow
Premenstrual syndrome

Birth control
What type:
Number of pregnancies:
Number of live births:
Number of miscarriages:
Number of abortions:
Difficulty conceiving
Menopause symptoms
History of Venereal Dz
Are you sexually active
Sexual difficulties

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Breasts

Do you do self exams
Lumps
Breast pain

Nipple discharge
Skin discoloration

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Male Reproductive System

Hernias
Testicular pain
Testicular masses
Discharges or sores

Are you sexually active
Sexual difficulties
Prostate disease/pain
Venereal disease

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Musculoskeletal

Joint pain/stiffness
Swelling of joints
Arthritis

Broken bones
Muscle cramps/spasm
Weakness

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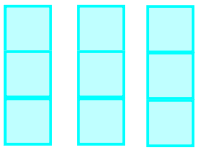
Peripheral Vascular

Coldness of hands/feet
Deep leg pain
Numbness of hands/feet

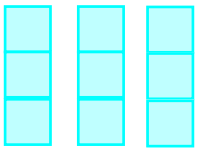
Varicose veins
Spider veins
Thrombophlebitis

Neurological

Dizziness
Fainting
Seizures



Numbness or tingling
Memory loss
Paralysis



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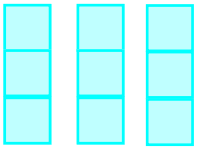
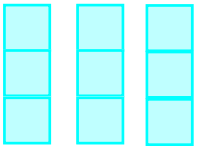
Mental/Emotional

Anxiety or nervousness
Depression
Excessive anger



Excessive fears
Mood swings
Tension/stress



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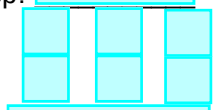
Habits

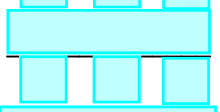
Do you awake rested

Sleep well
Average hours of sleep: _____
Enjoy your work

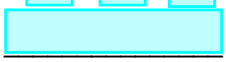


Watch television
How many hours/day _____

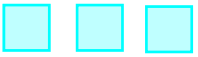
Work at a computer
How many hours/day _____



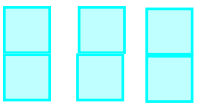
Read



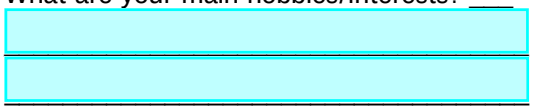
How many hours/day _____
Take vacations



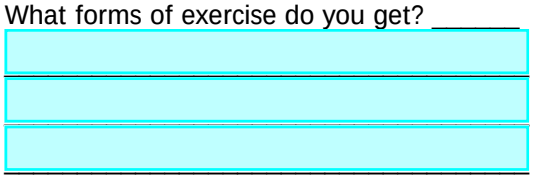
Do you use:
Recreational drugs
Alcoholic beverages



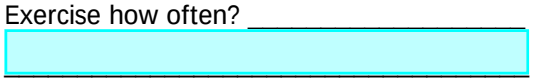
What are your main hobbies/interests? ___



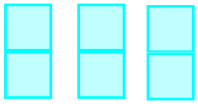
What forms of exercise do you get? _____



Exercise how often? _____



Have you been treated for:
Alcohol dependence
Drug dependence



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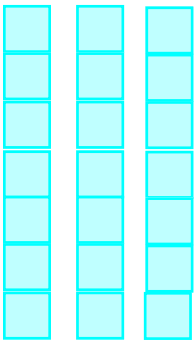
Infants & Small Children

Does your child:
Sleep through the night
Frequent sore throats
Constipation
Hyperactive
Constant runny nose
Skin rashes
Behavioral problems



Eat well
Frequent earaches
Diarrhea
Colic
Lethargic
Irritable
Abnormal weight loss/gain
Reaction to vaccinations