



Natural Health Care

Jared L. Zeff, ND, Lac, LLC 3606 Main St., Ste 201 Vancouver, Washington 98663
Ph: 360-823-8121 F: 360-823-8123 DrZeff@aol.com www.salmoncreekclinic.com

Name _____ Date _____
Age _____ Date of Birth _____ Sex F M
Address _____
City _____ State _____ Zip Code _____
Telephone (home) _____ (work) _____
E-mail _____
Occupation _____ Hours per wk _____ Retired _____
Employer _____ Education _____

Are you: Married ___ Separated ___ Divorced ___ Widowed ___ Single ___
Significant Partnership _____
Live With: Spouse ___ Partner ___ Relatives ___ Friends ___ Alone ___ Parents ___

Next of Kin or other to reach in an emergency _____
Relationship _____ Address _____
Phone _____

Health History Questionnaire

Holistic health care and preventive medicine are only possible when the physician has complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. **Print** all information and mark anything you don't understand with a question mark.

When and where did you last receive medical or health care? _____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____
- 5.) _____

For All New Patient Files:

The naturopathic community is interested in furthering the goal of naturopathic medicine through scientific investigations and research. Would you consent to our use of your medical records by qualified investigators under protocols approved by an appropriate Institutional Review Board? Your anonymity will be guaranteed. **Yes** _____ **No** _____

Signature _____ **Date** _____

Family History

Check those applicable	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____	_____
Health G:good F:fair P:poor	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma, Hayfever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

For the following sections, please circle Y=yes or N=no

Childhood Illness

Scarlet Fever	Y N	Diphtheria	Y N	Rheumatic Fever	Y N
Mumps	Y N	Measles	Y N	German Measles	Y N
Other	_____				

Hospitalization and Surgery

What hospitalizations or surgeries have you had? _____

X-Rays and Special Studies

X-rays, CAT Scans, or MRI's you have had: _____

Electrocardiogram	Y N	Electroencephalogram	Y N
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Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot (not antitoxin)	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Other	_____

Allergies

Please list any foods, drugs, or other allergens that you know of: _____

Current Medications

Do you take or use?			
Laxatives	Y N	Pain Relievers	Y N
Cortisone	Y N	Antacids	Y N
Tranquilizers	Y N	Sleeping Pills	Y N
		Thyroid Medication	Y N

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

Review of Symptoms

Y = a condition you have now. N = never had. P = a condition you have had in the past.

For the following, please circle.

General

Weight _____
 Weight 1 yr. ago _____
 Maximum Weight _____
 When _____
 Height _____
 Fatigue Y P N

Skin

Rashes Y P N
 Other skin conditions Y P N
 Itching Y P N
 Color Change Y P N
 Lumps Y P N
 Night Sweats Y P N

Head

Headaches Y P N
 Head Injury Y P N

Eyes

Impaired Vision Y P N
 Glasses or Contacts Y P N
 Eye Pain Y P N
 Tearing Y P N
 Dryness Y P N
 Double Vision Y P N
 Glaucoma Y P N
 Cataracts Y P N

Ears

Impaired hearing Y P N
 Ringing Y P N
 Earaches Y P N
 Dizziness Y P N

Nose and Mouth

Frequent Colds Y P N
 Sore Tongue Y P N
 Gum Problems Y P N
 Hoarseness Y P N
 Teeth Problems Y P N
 Sinus Problems Y P N

Neck

Lumps Y P N
 Swollen Glands Y P N
 Goiter Y P N
 Pain or Stiffness Y P N

Respiratory

Cough Y P N
 Sputum Y P N
 Spitting up Blood Y P N
 Wheezing Y P N
 Asthma Y P N
 Bronchitis Y P N
 Pneumonia Y P N
 Pleurisy Y P N
 Emphysema Y P N
 Difficulty Breathing Y P N
 Pain when Breathing Y P N
 Shortness of Breath Y P N
 At night Y P N
 Lying down Y P N
 Tuberculosis Y P N

Cardiovascular

Heart Disease Y P N
 Angina Y P N
 High Blood Pressure Y P N
 Murmurs Y P N
 Rheumatic Fever Y P N
 Chest Pain Y P N
 Swelling in ankles Y P N
 Palpitations, Fluttering Y P N

Gastrointestinal

Trouble Swallowing Y P N
 Heartburn Y P N
 Change in Thirst Y P N
 Change in Appetite Y P N
 Nausea Y P N
 Vomiting Y P N
 Vomiting Blood Y P N
 Bowel Movements
 How Often _____
 Is this a change _____
 Blood in Stool Y P N
 Belching or passing gas Y P N
 Jaundice (yellow skin) Y P N
 Liver Disease Y P N
 Gall Bladder Disease Y P N
 Ulcer Y P N
 Hemorrhoids Y P N

Urinary

Pain on Urination Y P N
Increased Frequency Y P N
Frequency at Night Y P N
Inability to hold urine Y P N
Frequent Infections Y P N
Kidney Stones Y P N

Female Reproduction

Age Menses Began _____
Average Number of days _____
Length of Cycle _____
Bleeding Between Periods Y P N
Are Cycles Regular Y P N
Pain during intercourse Y P N
Painful Menses Y P N
Vaginal problems Y P N
Excessive Flow Y P N
Birth Control Y P N

What Type? _____

Number of Pregnancies _____
Number of Live Births _____
Number of Miscarriages _____
Number of Abortions _____
Difficulty Conceiving Y P N
Menopausal Symptoms Y P N
Are you Sexually Active Y P N
Sexual Difficulties Y P N
Venereal Disease Y P N

Heterosexual _____

Bisexual _____

Homosexual _____

Breasts

Do You Self Exam Y P N
Lumps Y P N
Pain (or tenderness) Y P N
Nipple discharge Y P N

Male Reproductive

Hernias Y P N
Testicular Masses Y P N
Testicular Pain Y P N
Penis problems Y P N
Are you sexually Active Y P N
Sexual Difficulties Y P N
Prostate Disease Y P N
Venereal Disease Y P N
Discharge or Sores Y P N

Heterosexual _____

Bisexual _____

Homosexual _____

Musculoskeletal

Joint Pain or Stiffness Y P N
Arthritis Y P N
Broken Bones Y P N
Muscle Spasms Y P N
Weakness Y P N

Peripheral Vascular

Deep Leg Pain Y P N
Cold Hands and Feet Y P N
Varicose Veins Y P N
Thrombophlebitis Y P N

Neurologic

Fainting Y P N
Seizures Y P N
Paralysis Y P N
Muscle Weakness Y P N
Numbness or Tingling Y P N
Loss of Memory Y P N

Emotional

Depression Y P N
Mood Swings Y P N
Anxiety Y P N
Tension Y P N

Endocrine

Hypothyroid Y P N
Heat or Cold Intolerance Y P N
Excessive Thirst Y P N
Excessive Hunger Y P N

Blood

Anemia Y P N
Easy Bleeding or Bruising Y P N

Habits

What are your main hobbies and interests? _____

Do You Exercise? Y N
What Forms? _____

How Often do You Exercise? _____

Do you eat three meals daily Y N

Awaken rested	Y	N
Sleep well	Y	N
Average 6-8 hours sleep	Y	N
Enjoy your work	Y	N
Spend time outside	Y	N
Watch television	Y	N
How many hours a day	_____	
Read	Y	N
How many hours a day	_____	
Take vacations	Y	N
Been treated for drug dependence	Y	N
Use recreational drugs	Y	N
Use alcoholic beverages	Y	N
Been treated for alcoholism	Y	N
Use tobacco	Y	N