Issaquah Valley Natural Medicine

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(425) 391-7338 · Fax (425) 391-8330

Confidential Patient Profile

Date: _____

Name: _____ Sex: _____

Age: _____ Date of Birth: _____ Social Security Number: _____

Address: _____

City/State/Zip: _____

Home Phone: (____)_____ May we leave a message here: YES NO

Work Phone: (____)_____ May we leave a message here: YES NO

Cell Phone: (____) _____ May we leave a message here: YES NO

Name of Insured: _____ Date of Birth of Insured: _____

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear about us? _____

Present Health Concerns

Please list in order of importance.

1. _____
2. _____
3. _____
4. _____
5. _____

What goals do you have for your visit at the clinic today? _____

_____

What are your long-term health goals? _____

_____

Please list any prescription or over the counter medications you are currently taking.

Name of drug	Dose	Reason for taking	For how long	Who prescribed

Please list any vitamins, minerals, herbs, or other supplements you are currently taking.

Name of supplement	Dose	Reason for taking	For how long	Who prescribed

Please list any allergies you have to drugs, food, or inhalants (grass, pollen, etc).

_____

Past Medical History

Please list your current health care providers.

Name	Type	For what reason	Phone

Date of last full physical exam: _____ Results: normal other _____

Date of last blood work: _____ Results: normal other _____

Date of last urine test: _____ Results: normal other _____

Date of last PAP and pelvic exam: _____ Results: normal other _____

Date of last mammogram: _____ Results: normal other _____

Are you pregnant or is there any *chance* you are pregnant (females)? _____

Date of last menstrual period (females) _____

Are your cycles regular (females)? _____ How long are your cycles (females)? _____

Date of last prostate exam (males) _____ Results: normal other _____

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Surgeries and Hospitalizations

Type of procedure	Date	Reason for procedure

Major Illnesses, Trauma, and Accidents

Type	Date	Treatment	Outcome

Family History

Please check the appropriate box if any family members have had the following:

	Mother	Father	Brother	Sister	Grandparent	Your Children
Allergies	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Tendency	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Hypoglycemia	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Disorder	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐	☐

Psychosocial History

Single ☐ Married ☐ Significant other ☐ Name of spouse/partner _____

Children (Please list names, ages, and health issues): _____

_____

Are you sexually active? _____ If yes, is it with (circle one): male female both

Occupation: _____

Are you satisfied with your employment? _____

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Regular Current Exercise

Type	Duration	Frequency
_____	_____	_____
_____	_____	_____

Sleep Habits

How many hours a night do you sleep? _____ Are you satisfied with your sleep? _____

Do you have problems falling asleep, staying asleep, or waking up? _____

Energy and Stress Levels

How would you describe your energy levels? _____

How would you describe your stress levels? _____

How do you cope with stress? _____

Diet History

What is a typical breakfast? _____

What is a typical lunch? _____

What is a typical dinner? _____

What are typical snacks? _____

How many glasses of water do you drink each day? _____

Do you have any special dietary restrictions? _____

Do you have any indigestion, heartburn, bloating, burping, gas, or nausea after eating? _____

_____

Bowel and Urinary Habits

How often do you have a bowel movement? _____

Do you have any difficulty with bowel movements? _____

Do you have any blood or mucus in or on your stool? _____

How often do you urinate? _____

Do you have any pain, burning, incontinence, or other symptoms with urination? _____

_____

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Personal Habits

	Never used	Previously used	Currently use	Frequency of current use
Tobacco				
Alcohol				
Caffeine				
Recreational Drugs				

Review of Systems

Please check the "C" box if you currently have or the "P" box if you previously had any of the following.

C	P		C	P		C	P	
☐	☐	Anemia	☐	☐	Cancer	☐	☐	Kidney Stones
☐	☐	Blood Diseases	☐	☐	Asthma	☐	☐	Pain/Difficulty with Urination
☐	☐	Fatigue	☐	☐	Difficulty Breathing	☐	☐	Sexually Transmitted Disease
☐	☐	Dizziness	☐	☐	Tuberculosis	☐	☐	Thyroid Problems
☐	☐	Recurrent Headaches	☐	☐	Stomach Ulcers	☐	☐	Diabetes
☐	☐	Loss of Hearing	☐	☐	Constipation	☐	☐	Significant Ankle Swelling
☐	☐	Ringing in Ears	☐	☐	Diarrhea	☐	☐	Liver Disease
☐	☐	Recent Loss of Vision	☐	☐	Nausea	☐	☐	Hepatitis
☐	☐	Eye Pain	☐	☐	Recurrent Vomiting	☐	☐	Arthritis
☐	☐	Frequent Sore Throats	☐	☐	Chest Pain	☐	☐	Neck Pain/Stiffness
☐	☐	Numbness	☐	☐	Heart Disease	☐	☐	Low Back Pain/Stiffness
☐	☐	Weakness	☐	☐	Heart Failure	☐	☐	Bursitis
☐	☐	Tingling	☐	☐	Irregular Heart Beat	☐	☐	Hot and Swollen Joints
☐	☐	Nervousness	☐	☐	Hemorrhoids	☐	☐	Prostate Enlargement
☐	☐	Depression	☐	☐	Easy Bruising	☐	☐	Menstrual Cramps
☐	☐	Skin Problems	☐	☐	Frequent Nose Bleeds	☐	☐	Heavy Menstrual Flow
☐	☐	Brittle Nails	☐	☐	Varicose Veins	☐	☐	Irregular Menstrual Cycles
☐	☐	Recent Hair Loss	☐	☐	Poor Circulation	☐	☐	Fibrocystic Breasts
☐	☐	Allergies	☐	☐	Stroke			
☐	☐	Frequent Sinus Infections	☐	☐	Kidney Failure			

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