Eclectic Naturopathic Medical Center, LLC

Patient Profile

Date:_____

Last Name:_____ First Name_____ M / F_____ Birth date:_____/_____/_____

A note to our patients: Please complete this questionnaire as thoroughly as possible in order to aid the doctor in your treatment. This information is *confidential* and will not be released without your expressed written consent.

PRESENT HEALTH CONCERNS

Please list health concerns in order of their significance.	Has this problem been previously diagnosed? If so, what was the diagnosis?
1.	1.
2.	2.
3.	3.

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____ _____

_____ _____

_____ _____

_____ _____

Bring all prescriptions and supplements in original bottles to your office visit.

LIST ALL SUPPLEMENTS, HERBS, AND HOMEOPATHICS YOU ARE CURRENTLY TAKING:

_____ _____

_____ _____

_____ _____

_____ _____

LIST ALL ALLERGIES TO MEDICATIONS: _____

_____

LIST ALL PREVIOUS SURGERIES_____

Medical Diagnostic Exams/Labs/Screenings: Please list approximate dates and results below

PAP Smear / Date: _____ / Results: _____

EKG/ Stress Test / Date: _____ / Results: _____

Blood Work / Date: _____ / Results: _____

Mammogram / Date: _____ / Results: _____

Chest X-ray / Date: _____ / Results: _____

Urinalysis / Date: _____ / Results: _____

DEXA/ Bone /
Density Scan / Date: _____ / Results: _____

Colonoscopy / Date: _____ / Results: _____

Last Menstrual Period / Date: _____

Bring a copy of all recent labs and imaging studies.

Family Medical History: Please indicate if any family members have had any of the following conditions:
(**M**= mother; **F**= father; **S**=sister; **B**=brother, **GM-M**= maternal grandmother; **GM-P=** paternal grandmother; **GF-M=**maternal grandfather, **GF-P=** paternal grandfather; **C=** your children))

Allergies_____	Diabetes_____	Hypoglycemia_____
Alcoholism_____	Endocrine/hormone _____	Kidney disorder_____
Asthma_____	Genetic/ Congenital / Inherited condition_____	Liver problems_____
Bleeding tendency_____	Heart disease_____	Neurological disorder_____
Cancer /Type_____	High Blood Pressure_____	Tuberculosis_____
Depression/Anxiety_____	High Cholesterol_____	Other_____

Patient Symptoms Checklist: Please indicate if you currently **(C)** suffer from any of the follow, or if you have suffered from a condition in the past **(P):**

Alcoholism_____	Diarrhea_____	Insomnia_____	Sinus problems_____
Acne_____	Dizziness_____	Interrupted sleep_____	Skin problems_____
Asthma_____	Dry skin_____	Irregular Menses_____	Stroke_____
Anemia_____	Dry/ Brittle nails_____	Joint pain_____	Spine problems_____
Anxiety_____	Ear pain/ringing_____	Kidney/pain/infection_____	Tremor_____
Arthritis_____	Eye pain_____	Leg pain_____	Tuberculosis_____
Back pain_____	Visual changes_____	Lumps in breast_____	Ulcers_____
Bad breath_____	Fatigue_____	Mood Swings_____	Vaginitis_____
Bloating/Gas_____	Fluid/water retention_____	Nausea_____	Varicose veins_____
Bruise easily_____	Foot pain_____	Neck pain_____	Weight gain_____
Bursitis_____	Forgetfulness_____	Night sweats_____	Weight Loss_____
Bloody stools_____	Frequent colds_____	Nosebleeds_____	Yeast infections_____
Cancer_____	Frequent urination_____	Numbness/tingling_____	Other_____
Chest pain_____	Hay fever_____	Mucus/Phlegm_____	_____
Chronic fatigue_____	Headaches	Poor Circulation_____	_____
Cold hands/feet_____	HIV_____	PMS_____	_____
Constipation_____	Herpes/cold sores_____	Poor digestion_____	_____
Cough_____	Heartburn/GERD_____	Prostate issues_____	_____
Cramps_____	Heart palpitations_____	Shortness of Breath_____	_____
Decreased Sex drive_____	High Blood Pressure_____	Shakiness if hungry_____	
Depression_____	Hemorrhoids_____	Sciatica_____	
Diabetes_____	Hot flashes_____	STD history_____	

Diet*:*

Please describe a typical Breakfast, Lunch and Dinner.

Breakfast:
Snack:
Lunch:
Snack:
Dinner:
Snack:

What do you drink during the day?

_____ _____

_____ _____

How much alcohol do you drink per day/week?_____

Exercise: Describe the amount and type of exercise you participate in on a weekly basis?

_____

Sleep: Describe your sleep. (Hours per night, interrupted sleep, sound sleep, difficulty falling asleep, etc.)

_____

Environmental: Please list any chemicals, fumes, dust particles, pesticides or other toxins to which you are exposed.

_____

Smoking: Do you smoke or are you exposed to smoke? If so, how much and for how long?

_____

Stress: Are you frustrated by your current situation (home, work, family, relationships)?

_____

Sex: Are you currently in a committed relationship?

_____

Do you practice safe sex?

_____

Spiritual:

Do you have a religious/spiritual orientation/practice that is important to you? Are there any products that the doctor might suggest that may be against your beliefs (e.g. Non-Kosher products, animal-based vs. vegan products, digestive enzymes derived from pork?). Please elaborate freely (note: our office can accommodate various food/religious concerns that you might have):

_____

_____

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS EXTENSIVE FORM. YOUR EFFORT WILL ASSIST THE DOCTOR IN DETERMINING AN ACCURATE DIAGNOSIS AND APPROPRIATE INDIVIDUALIZED TREATMENT PLAN.