CONFIDENTIAL HEALTH HISTORY

Patient Name _____ Today's Date _____
Birthdate _____ Reason for Visit _____

Check symptoms you currently have or have had in the past year.

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Light Sensitivity
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervous/Tension
- ☐ Numbness
- ☐ Shortness of Breath
- ☐ Sweats

Muscle/Joint/Bone
Pain, weakness, numbness or Decreased range of motion in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Shoulders
- ☐ Jaw/TMJ
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Hands

Gastrointestinal
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ High Cholesterol/Lipids
- ☐ Irregular or Rapid Heart Beat
- ☐ Poor Circulation
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Eye, Ear, Nose, Throat
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache/Ear Discharge
- ☐ Hayfever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Changes

Urinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

Skin
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in Mole/s
- ☐ Sore that won't heal

Men Only
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other

Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Menstrual Cramps
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other _____

Date of last:
Menstrual Period _____
Pap Smear _____
Mammogram _____
Are you Pregnant? ____
Number of:
Pregnancies _____
Children _____

Check conditions you currently have or have had in the past year.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies/Hayfever
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto-immune Disease
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Mental Illness
- ☐ Migraine
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Neurological Disorder
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thrombosis/Embolism
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Sexually Transmitted Disease

MEDICATIONS _____
DRUG ALLERGIES _____

Dr. Kate D'Archangel, ND, LMP 25995 Barber Cut Off Rd NE, Ste B3, Kingston, WA 98346

PATIENT NAME_____ DATE_____

CURRENT HEALTH CONCERNS

Present injury or health concern:_____
Date of injury or onset of problem:_____ Pains are: ☐ sharp ☐ dull ☐ constant ☐ intermittent
What activities aggravate your condition?_____
What activities alleviate your condition?_____
This condition interferes with: ☐ Work ☐ Sleep ☐ Exercise ☐ Routine ☐ Other_____
Are you seeing another health care provider for this condition?_____

PAST MEDICAL HISTORY

Have you ever been hospitalized or had surgery?_____
For what reasons?_____
Number of Pregnancies Year/s of birth_____
Complications during pregnancy or delivery?_____
Have you ever had a blood transfusion?_____ Approximate date:_____
Serious illnesses or injuries?_____

HEALTH HABITS

Check which substances you use: ☐ Caffeine ☐ Tobacco ☐ Alcohol ☐ Recreational Drugs
Check any work exposures: ☐ Stress ☐ Heavy Lifting ☐ Hazardous Substances ☐ Other_____
Occupation_____
Diet Restrictions/Regimens? Please describe_____
Food allergies or sensitivities? Please list_____
Please list any supplements (vitamins, minerals, herbs, amino acids, etc.) you are currently taking._____
_____

FAMILY HISTORY

Relation	Age	State of Health	Cause of Death/Age	Check if your blood relatives had any of the following Disease	Relationship to you
Father				Arthritis/Gout	
Mother				Asthma, Hayfever	
Siblings				Cancer	
				Diabetes	
				Heart Disease, Stroke	
				High Blood Pressure	
				Kidney Disease	
				Mental Illness	
				Substance Abuse	
				Tuberculosis	
				Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my health care provider responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date