Yellow Pine Naturopathic Clinic

Dr. Margaret Coffey, ND
406-351-0131
www.yellowpineclinic.com

New Patient Health History

The following intake questions help us to anticipate your health care needs and gain a more complete understanding of you as a person.

Name: _____ Date of Birth: _____

Present Health Concerns:

Please list your health concerns in order of priority, including date of onset.

1._____

2._____

3._____

4._____

What is your primary goal for today's visit? _____

_____

Other Healthcare Providers: Please list your current medical practitioners.

Specialty	Name	City

Medications/Supplements: (Continue on back if necessary)

Name of item	Dose	Reason

Allergies: Please list any medications, foods, or other substances to which you are allergic:

_____

_____

On the continuum below, please indicate your current state of well being with a check mark.

Excellent_____Poor

Medical history:

Please list any hospitalizations and/or surgeries:

_____

_____

_____

Please list any major illnesses including childhood:

_____

Date & result of last colonoscopy: _____ or never

Date & result of last bone density screen: _____ or never

Please list any other diagnostic imaging studies (X-ray, CT, MRI etc) in last 5 years:

_____

Have you had labs within the last 12 months? If so, where and/or with whom?

_____

Please circle if you have: Corrective Lenses Dentures Hearing aid Other device:_____

Immunization history (please circle most appropriate choice):

None Unsure, probably all Per military protocol Other

Review of Systems

Current height: _____ Current weight: _____

Are you concerned about your current weight? Yes No

For the following, please circle N for something you have now or P for something you had in the past:

General		**Skin**		**Mouth/Throat**	
Unintentional weight gain or loss of 10+ lb	N P	Rash	N P	Difficulty swallowing	N P
Significant fatigue	N P	Easy bruising	N P	Gum disease	N P
Night sweats	N P	Hair loss or change	N P	Dental cavities	N P
Autoimmune illness	N P	Nail problems	N P	Other:	N P
Genetic condition	N P	Other:	N P		N P
Cancer diagnosis	N P		N P		N P
Allergies	N P	**Head/neck**		**Nose/Sinus/Ears**	
Insomnia	N P	Headaches	N P	Nose bleeds	N P
Other:	N P	Head injury	N P	Sinus infections	N P
		Painful or stiff neck	N P	Recurrent ear infections	N P
		Other:	N P	Hearing Loss	N P
				Ringing	N P
				Other:	N P

Eyes		**Digestive Tract**		**Musculoskeletal**	
Eye pain	N P	Belching	N P	Joint pain/stiffness	N P
Dry eyes	N P	Gas/bloating	N P	Muscle cramps	N P
Cataracts	N P	Heartburn/reflux	N P	Back pain	N P
Vision change	N P	Vomiting	N P	Bone loss	N P
Other:	N P	Diarrhea	N P	Other:	N P
		Constipation	N P		
Respiratory		Abdominal pain	N P	**Nervous system**	
Shortness of breath	N P	Blood or mucus in stool	N P	Difficulty with balance	N P
Wheezing	N P	Incontinence	N P	Numbness/tingling	N P
Asthma	N P	Diverticulitis/Diverticulosis	N P	Loss of sensation	N P
Chronic cough	N P	Hemorrhoids	N P	Dizziness	N P
Difficulty breathing	N P	Liver disease/problem	N P	Memory loss	N P
Other:	N P	Gall bladder problems	N P	Other:	N P
		Hernia	N P		
Cardiac		Other:	N P	**Emotional**	
Chest pain	N P			Mood swings	N P
Known heart disease	N P	**Urinary**		Sadness/depression	N P
High cholesterol	N P	Pain with urination	N P	Anxiety/nervousness	N P
High blood pressure	N P	Urinary frequency	N P	Anger/irritability	N P
Low blood pressure	N P	Urinary urgency	N P	Panic attacks	N P
Skipped/irregular beats	N P	Infections	N P	Difficulty concentrating	N P
Fainting	N P	Incontinence	N P	Trauma/abuse	N P
Swollen ankles	N P	Difficulty urinating	N P	Consider suicide	N P
Varicose veins	N P	Kidney stones	N P		
Cold hands/feet	N P	Other:	N P		
Other:	N P				

For men:

Are you currently sexually active? Yes No Past, not currently

Type of contraception used: _____ Satisfied with your contraception? Yes No

Are you concerned about the possibility of a sexually transmitted infection? Yes No

Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 (0 = no libido)

Sexual function: Great, no complaints Starting to have troubles Trouble

Are you taking hormones of any kind? Yes No

Please circle N for Now and P for Past.

Penile pain	N P	Testicular pain	N P	Genital sores	N P
Penile discharge	N P	Scrotal pain	N P	Prostate problems	N P
Other:	N P				

For women:

Are you currently sexually active? Yes No Past, not currently

Type of contraception used: _____ Satisfied with your contraception? Yes No

History of contraception: _____

Are you concerned about the possibility of a sexually transmitted infection? Yes No

Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 (0 = no libido)

Sexual function: Great, no complaints Starting to have troubles Trouble

Are you taking hormones of any kind? Yes No

Age when menstruation started: _____ Age when ended (if appropriate): _____

Frequency of period: every ___ days; Duration of period: ___ days; Date of last period: _____

Any concerns about your period: _____

Number of pregnancies: _____ Miscarriages: _____ Abortions: _____

Currently pregnant: Yes No Unsure Currently breastfeeding: Yes No

Date of last mammogram and results: _____ or never

Date of last pap smear and results: _____ or never

Any abnormal paps or mammograms? Yes No

Please circle N for Now and P for Past.

Breast lumps	N P	Nipple discharge	N P	Vaginal discharge	N P
Breast changes	N P	Pelvic pain	N P	Genital sores	N P
Other:	N P				

Family history:

My mother's health is: Good Fair Poor Deceased at age _____ Unknown

My father's health is: Good Fair Poor Deceased at age _____ Unknown

I = immediate family member (father, mother, sibling, child); R = remote family member (grandparent, cousin…)

Alcohol/drug abuse	I R	Cancer	I R	High blood pressure	I R
Arthritis	I R	Depression or anxiety	I R	Other heart disease	I R
Autoimmune disease	I R	Diabetes	I R	Other:	I R
Bleeding disorder	I R	Heart attack	I R		

Social history:

Occupation: _____ Hours per week: _____ Satisifed: Yes No

Stress level: Low Medium High Stress managed well? Yes No

With whom do you live? Spouse/Partner Children Alone Parents Other

Sleep patterns: less than 6 hrs 6-8 hrs 8+ hrs can't fall asleep can't stay asleep

Other: _____

Do you eat 5-7 servings of vegetables and fruits per day? Yes Sometimes No

Any foods you avoid: _____

How much sugar do you have daily? None Low Moderate High

How many times do you eat fast food in a week? 0 1-2 3-4 5-6 7+

Amount of water daily: _____ Other drinks: _____

How much caffeine do you have daily? None Low Moderate High

Number of alcoholic drinks per week, on average: None 0-1 2-5 6-10 11+

Do you use tobacco now? Yes No If yes, how much and how often?_____

Did you use tobacco before? Yes No If yes, how much & how often?_____

Do you exercise on a regular basis? Yes No

If yes, please briefly describe:_____