

Please print **Salish Island Naturopathic.L.L.C., Dr. Trina Doerfler, N.D.,D.C.**

Name (first, middle, last) \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please give names and dates **PAST HISTORY**

Major Illnesses: \_\_\_\_\_ Medications: \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

Previous hospitalizations or surgeries: \_\_\_\_\_

**NOW**

STRENGTHS/WEAKNESSES: \_\_\_\_\_

What practices or activities do you use to sustain your health and well being? \_\_\_\_\_

Who do you turn to for support? Who are in your community? \_\_\_\_\_

Who lives in your household? \_\_\_\_\_

What causes stress for you? \_\_\_\_\_

DIET: Fast Food All American Vegetarian Balanced Other

SMOKING: Packs per day \_\_\_\_\_ Number of years \_\_\_\_\_ Years stopped \_\_\_\_\_ Pipe Cigar Chew

ALCOHOL: Never Occasional Moderate Heavy Alcohol Problem? Y N How much each week?

EXERCISE: Never Occasional Moderate Often Favorite types?

CAFFEINE: Coffee: \_\_\_\_\_ cups per day Tea: \_\_\_\_\_ cups per day

Height: \_\_\_\_\_ Weight \_\_\_\_\_ Weight at age 20 \_\_\_\_\_ Weight change last year: gain lbs. lost lbs.

OCCUPATIONAL EXPOSURES: \_\_\_\_\_ Asbestos \_\_\_\_\_ Other (describe) \_\_\_\_\_

**DRUGS:** Please check off drugs presently used and explain frequency of use (daily, weekly, etc.)

Sleeping pill	Allergy medicine(s)	Blood thinner	Antibiotics
Tranquilizer	Nose sprays	"Hard drugs"	Asthma medicine
Anti Depressant	Cortisone/steroids	Marijuana	Shots
Pain pill	Thyroid	Cocaine	Other(s) - Specify
Diet pill	Heart pill	Laxative	
Diabetes pill	Digitalls	Antacids	
Estrogen hormone	Nitroglycerin	Decongestant	
Birth control pill	Water pill (diuretic)	Vitamins	
Insulin	Blood pressure pill	Iron	

**ALLERGIES:** Food sensitivities: \_\_\_\_\_ **FAMILY HISTORY:** WHO: \_\_\_\_\_ **FAMILY HISTORY (cont.):** WHO: \_\_\_\_\_

Drug allergies/Type of reaction: \_\_\_\_\_ Diabetes \_\_\_\_\_ Anxiety \_\_\_\_\_  
 \_\_\_\_\_ Heart disease \_\_\_\_\_ Depression \_\_\_\_\_  
 \_\_\_\_\_ High blood pressure \_\_\_\_\_  
 \_\_\_\_\_ Thyroid \_\_\_\_\_ CHILDRENS AGES/NAMES \_\_\_\_\_  
 \_\_\_\_\_ Stroke \_\_\_\_\_  
 \_\_\_\_\_ Cancer(what kind) \_\_\_\_\_  
 \_\_\_\_\_ Alcoholism \_\_\_\_\_

# SALISH ISLAND NATUROPATHIC, LLC: HEALTH HISTORY

What brings you in today?:

**SYSTEM REVIEW: Check if you have any symptoms or problems to any important or significant degree.**

Tired all the time	Frequent chest colds	Indigestion	Sugar in urine
Don't feel well	Bronchitis	Heartburn	Hypoglycemia
Weakness	Pneumonia	Nervous stomach	Low blood sugar
Weight problem	Shortness of breath	Ulcers	Thyroid trouble
Fluid retention	Asthma/wheezing	Vomiting blood	DATE OF last urinary or bladder infection:
Lack of exercise	Hayfever	Black or bloody stools	
DATE OF LAST PHYSICAL EXAM:	Pleurisy	Rectal bleeding	Bladder problems
	Chest pain	Abdominal pain	Kidney infection
Headache	Heart trouble	Nervous or spastic colon	Kidney trouble
Migraine	Heart murmur	Colitis	Kidney stone
Fainting	Heart palpitation/racing	Diarrhea	Difficulty with urine
Dizziness	Chest tightness/pressure	Constipation	Protein or blood in urine
Epilepsy/seizure	Angina	Change in bowel habits	Sexually transmitted disease
Ear/hearing problem	Tire easily	Hemorrhoids	Skin rash
Ringing in the ears	Enlarged heart	Gall bladder trouble	Skin trouble
Stuffy nose	Rheumatic fever	Hepatitis	Allergy
Nose bleeds	Leg pain on walking	Liver disease	Food avoidance
Sinus trouble	Varicose veins	Hernia	Bleed or bruise easily
DATE OF LAST DENTAL EXAM:	Phlebitis	Food intolerance	Anemia
	Ankle/leg swelling	Nervous	Blood disease
Persistent hoarseness	DATE OF LAST CHEST X-RAY:	Tense/irritable	Infertility problem
Glasses		Bored	Sexual difficulty
Vision/eye trouble	DATE OF LAST Electrocardiogram:	Depressed	
Glaucoma		Trouble sleeping	<b>MEN ONLY:</b>
Cataract	Arthritis/joint pain	Relationship problems	Discharge from penis
DATE OF LAST EYE EXAM:	Gout	Job problems	Prostate trouble
	Neck pain	Personal problems	Stream weak or slow
Frequent cough	Back pain or trouble	Nervous breakdown	Swelling or pain in testes
Cough phlegm	Bursitis/tendinitis	Psychiatrist seen	DATE OF VASECTOMY:
Cough blood	Swallowing trouble	High blood sugar	

**WOMEN ONLY:**

Age menstruation began: \_\_\_\_\_ Periods: \_\_\_Regular \_\_\_Irregular \_\_\_Painful \_\_\_Heavy Every \_\_\_\_\_ days

Comments: \_\_\_\_\_ Last menstrual period date(s): \_\_\_\_\_

Number of PREGNANCIES: \_\_\_\_\_ Number of BIRTHS: \_\_\_\_\_ Number of Miscarriages/Abortions: \_\_\_\_\_

Dates of PREGNANCIES / outcome: \_\_\_\_\_

Type of birth control: \_\_\_\_\_ How Long? \_\_\_\_\_ IUD? \_\_\_Yes \_\_\_No Years inserted \_\_\_\_\_

Date of last mammogram \_\_\_\_\_ History of breast disease? \_\_\_\_\_

Symptoms of menopause? \_\_\_\_\_

(Additions to health history)