Dr. Wendy Van Dilla, Naturopathic Physician
(505) 986-1370

Health History Summary

Date_____

Name_____ Age____ Birthdate_____ Blood type____

Address_____ City_____ State____ Zip_____

Phone(home)_____ (work)_____daytime or eve?

Occupation_____ (full/part time?) Employer_____

Insurance Co._____Policy #_____ Soc Sec #_____

Address _____City_____ State_____ Zip_____

Nearest Relative_____ Phone_____
what is their relationship to you

Who else can we reach in case of emergency?_____ Phone_____
what is their relationship to you

How did you hear about Wholistic Health Care? _____

Last physician or health practitioner seen?_____ When?_____

When was your last blood test?_____ What kind?_____

Your Current Health Problems

What is your main reason for coming in today? If you have a specific health condition please describe in detail. When was the very first time that you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation.

List in order of importance other health problems that are troubling you:

1)_____ & length of time_____

2)_____ & length of time_____

3)_____ & length of time_____

4)_____ & length of time_____

Other problems:_____

How long has your main problem been troubling you?_____

Is your current "main problem" getting *[better, worse, same]* and for how long?_____

_____

What kind of treatment have you received and from whom?_____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current problem? *(yes or no)* or for any problem? *(yes or no).*

What was the therapy and what were the results?_____

_____

Your Health History

The general state of your health is: **(excellent___) (good___) (avg___) (fair___) (poor___),** and on the average describe your energy level from 1-10 (10 is highest & 1 lowest) "_____"

When during the day is your energy the best?_____ worst?_____

What is your current approximate weight?_____ height?_____ Weight one year ago_____

As an adult what has been your maximum_____ and minumum weight_____ **(do not include pregnancy)**

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? *(yes or no) Please circle*

1) _____ date_____

2) _____ date_____

3) _____ date_____

4)_____ date_____

5)_____ date_____

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist?_____ Have you in the past?_____ If so when?(give dates)_____

Are you currently working with a Doctor of conventional medicine?(M.D. or D.O.)*(Yes or No)*

What childhood illnesses have you had? (check off if had)

measles _____	mumps_____	chickenpox_____	whooping cough____
polio _____	diphtheria_____	rheumatic fever_____	scarlet fever_____
smallpox_____	typhoid fever_____	tuberculosis_____	mono___ how long__

Previous surgeries and hospitalizations (include dates)_____

_____

Which of the following have you had and indicate "now or past" & also how often and when.

now or past	year	now or past	year	now or past	year
____pneumonia	_____	____diabetes_____		_____gonorrhea_____	
____tonsillitis	_____	____asthma _____		_____syphilis	_____
____ear infections	_____	____eczema_____		_____venereal disease	____
____chronic infections_____		____heart disease____		_____epilepsy _____	
____canker sores	_____	____herpes_____		_____high blood pressure____	
____allergies_____		____hepatitis_____		_____mononucleosis____	
____thyroid problems_____		____weight prob.____		_____anemia	_____
____others_____					

Do you have any allergies to any drugs, herbs, foods, animals or other? *(Y or N)* What? _____

_____

Which of the following do you currently use?

amount (how often, how much & how long) amount (how often, how much & how long)

alcohol_____ tobacco_____

hormones _____ coffee_____

cortisone _____ laxatives_____

sedatives _____ antacids_____

other medications (please give full name and doseage and how long have you been taking the medication)

_____/ _____/ _____

_____/ _____/ _____

_____/ _____/ _____

vitamins\herbs_____/ _____/_____/_____

_____/ _____/ _____/ _____/ _____

_____/ _____/ _____/ _____/ _____

Family History

Please list ages, health problems and if deceased, cause of death:

	Living(age?)	Health Problems	Died (age?)	Cause
Your Mother	_____	_____	____	_____
Your Father	_____	_____	____	_____
Your Brothers	_____	_____	____	_____
	_____	_____	____	_____
	_____	_____	____	_____
Your Sisters	_____	_____	____	_____
	_____	_____	____	_____
	_____	_____	____	_____
Grandmom & granddad				
Mother's Mom	_____	_____	____	_____
Mother's Dad	_____	_____	____	_____
Grandmom & granddad				
Father's Mom	_____	_____	____	_____
Father's Dad	_____	_____	____	_____

What is your nationality? *(please list all backrounds & give approximate %)*_____

_____

You currently live with? spouse___ partner___ parents___ friends___ children___ alone____

Are you? married____ separated___ divorced___ widowed___ single___ in a supportive relationship___

What is your current level of education?_____ Are you satisfied with this? ***(Yes or No)***

Do you have any children?_____ How many? _____ Ever have Toxemia during preg. (Y or N)

Do they have any health problems?_____

Do you have any blood relative aunt uncle or grandparent who has had any of the following?

____allergies	____arthritis	____asthma	____cancer	____diabetes
____anemia	____depression	____skin disease	____heart attack	____genetic prob
____High B.P.	____stroke	____ulcers	____cataracts	____thyroid prob
____hypoglycemia	____seizures	____sickle cells	____venereal disease	

What is your weakest organ system and why?_____

Personal Habits

What do you enjoy most in your life?_____

What are your main interests or hobbies?_____

What do you worry most about in life?_____

Do you exercise? *(yes/no)* If yes what kind, how much & how often?_____

Do you have a religious or spirtual practice? *(Yes/No)* If yes, what?_____

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) _____

Do you have problems *(falling or staying asleep)*? ____ How many hrs do you sleep at night?____

Do you awaken at night? *(yes or no)* If yes what time(s) do you usually wake up?_____

Do you ever sweat at night while sleeping? *(yes or no)*. How frequently and how much do you sweat?_____ Do you wake up feeling refreshed? *(yes or no)*

Do you nap or rest horizontally throughout the day? *(yes or no)*. For how long? _____

What do you normally feel like temperature wise, compared to others? *(warm or cooler or avg)*

What are the temperatures of your hands and feet generally? *(warmer or cooler or average)*

Do you enjoy your work? *(yes or no)* Do you take vacations? *(yes or no)*

Are you currently in a happy satisfying relationship with someone? *(Very, mostly, somewhat, not)*

How often do you get colds, flus, sore throat, yeast infections during the year?_____

When you rise quickly from a sitting or lying position do you ever get dizzy? *(yes or no) If yes how often?(daily; few times per week; 1x week; 2x per month; 1x per month; rarely)*

Female reproduction

Age of first menses_____ If periods have stopped at what age did they stop?_____

Are your cycles regular *(Y N)* Period begins every _____ days. How long periods?_____

Are your periods *(Heavy, medium, light)* & what color is blood?*(light red, dark red, medium, clots)*

Do you have any spotting or bleeding between periods *(Y / N)* Any cramps with period *(Y / N)*

Do you have any premenstrual symptoms ?*(water retention, breast tenderness, irritability, depression, headaches, mood swings, food cravings)* other _____

Number of pregnancies_____ Number of abortions_____ Number of live births?_____

Number of miscarriages_____ Any problems gettting pregnant?_____

Do you get yearly PAP smears?*(Y /N)* Any abnormal PAP's? *(Y / N)* Breast lumps?*(Y / N)*

Are you currently sexually active?*(Y N)* How often?_____ Is this *(more or less)* than 1 yr ago?

Do you use birth control? *(Y / N)* What type of birth control do you currently use?_____

Have you ever been physically or sexually abused? *(Y/N)* How old and how often?_____

Male Reproduction

How often do you have to get up at night to urinate?____ Is this an increase in past few yrs?*(Y/N)*

Any problems with impotency? (getting or maintaining an erection) *(Y/N)*. Any sores on penis? *(Y/N)*.

Do you have any abnormal discharge from the penis? *(Y/N)* Any veneral diseases? *(yes or no)*

Any prostate problems? (Y/N & *past/now)* Ever have your prostate examined?(Y/N). When?_____

Are you currently sexually active?*(Y/N)* How often?_____ Is this *(more or less)* than 1 yr ago?

Do you use birth control? *(Y or N)* What type of birth control do you currently use?_____

Have you ever been physically or sexually abused? *(Y/N)* How old and how often?_____

Digestion and Elimination

Digestion *(circle or fill in the answer)*

Do you have any problems with gas, bloating or fullness after eating? (Yor N). How often do you have gas, fullness or bloating after eating? ***(often, sometimes, never)***. How severe?_____
Do you have gas in ***(the upper part of the abdomen or lower part or both areas)***?

How long have you had this problem?_____

How often do you have bowel movements?_____

Do you ever have any **(blood, mucus, undigested food, black stools)**?

Any rectal itching? (Y/N) Do your stools tend to be ***(formed or loose)***? How often do you have diarrhea?_____Do you ever have alternating constipation and diarrhea? (Y N)

How often do you have thin, long and narrow stools? ***(often sometimes never)***

How often do you have small & hard stools?***(often, sometimes, never)***

Do you ever have yellow or light colored stoolsS? ***(often, sometimes, never)***

How often do your stools have a strong disagreeable odor? ***(often, sometimes, never)***

Have you ever fasted? ***(yes or no; juice or water)*** For how long have you fasted?_____

How did you feel while you were fasting?_____

Have you traveled outside the U.S. in last 5 years? ***(Y/N)*** *Have you gone camping in last 5 yrs?(Y/N,*

Kidneys and bladder

Have you had recurrent bladder infections?***(Yes or No)*** How were they treated?_____

How many bladder infections have you had in the last 3 years?_____

Do you have any burning sensation during or after urination? ***(Past or Present or now)***

Is your urine ***(dark yellow, bright yellow, cloudy, pale or clear)?***

Does your urine have a strong odor to it? ***(Yes or No)***

Do you have difficulty starting or stopping when urinating? ***(Yes or No)***

Do you have difficulty perspiring? ***(Y N)***.. Do you perspire when you exercise? ***(lightly, moderately, heavily)***. Do you perspire other times than when exercising? ***(Y N)*** When?

Does your perspiration have a strong smell? ***(Yes or No)***

Does your temperature tend to run ***(low or high or average)***compared to others?*(circle one)*

Occupational/household

How long have you lived at your present address?_____ Where have you lived previously? _____***(Please describe location, if old or new place, i.e., new construction, damp or moldy)***

Do you have specialized air filtration at home? ***(yes or no)*** *Do you live in city?* ***(Yes or No)***

Do you work in an office building? ***(yes or no)*** Do the windows open? ***(yes or no)***

Do you have specialized air filtration at your work place? ***(yes or no)***

Do you work in the presence of toxic fumes or chemicals? ***(yes or no)***

Do any of your hobbies involve toxic materials? ***(yes or no)***

Are you exposed to second hand smoke currently? ***(yes or no)***

What do you use for your drinking water? ***(bottled, filtered, or tap water)***

Do you have anything else you would like to comment on? _____

Diet

What do you typically eat for:
Breakfast

Lunch

Dinner

Snacks (what time of day?)

Beverages (with meal or between?)

Dental History

Hygiene:

What is your daily oral hygiene routine? (brush, floss, gum stimulator)

What products do you use? (type of toothbrush, toothpaste, mouthwash, waxed or unwaxed floss, gum irrigator eg Water pik or HydroFloss)

Teeth:

How many silver mercury amalgam fillings do you have and for how long?

How many composite fillings do you have and for how long?

How many of the following do you have and for how long?

Root canal

Crowns/inlays/onlays

Bridges

Partial dentures

Full mouth dentures

Implants

Extractions

Appliances:

Do you wear a splint or mouth guard?

How long and when during the day or night?

When did you start wearing this?

Oral Conditions and Diseases:

Do you currently have, or had in the past, any of the following:

Periodontal disease

Abcess

Tonsils/adenoids removed?

Clench and/or grind teeth? Day and/or night?

TMJ (temporal mandibular joint pain syndrome)