



Date _____

Personal Information

First Name _____ Middle _____ Last _____

Date of Birth _____ Male Female

Address _____ Apt No. _____

City _____ State _____ Zip code _____

Email: _____

Phone: Mobile () _____ Home () _____ Work () _____

Preferred method of contact: cell phone home phone email

Ok to leave message with detailed information or Leave message with call-back number only.

Emergency contact

Name _____ Relationship _____ Phone _____

Insurance carrier _____

Responsible party for Insurance (if applicable)

Who is responsible for the account? (If it is yourself, please just write "self" on name line. We will make a copy of your insurance card at the first visit.)

Name _____ Relationship to patient _____

Date of Birth _____ Employer _____

Please tell us how you heard of our practice by checking one of the following

Relative Friend Insurance website Web search Ad Physician referral



HEALTH HISTORY

Name: _____ Date of Birth: _____

The main concern or reason(s) for seeing the doctor today is/are: _____

Other illnesses or health goals (please give date of onset when appropriate): _____

Allergies (medication, food, pollen) no known drug allergies

Prior hospitalizations/surgeries/traumas (include dates): _____

Medications/Supplements

| | | | |
|------------|------------|------------|------------|
| Name _____ | Dose _____ | Name _____ | Dose _____ |
| Name _____ | Dose _____ | Name _____ | Dose _____ |
| Name _____ | Dose _____ | Name _____ | Dose _____ |
| Name _____ | Dose _____ | Name _____ | Dose _____ |
| Name _____ | Dose _____ | Name _____ | Dose _____ |

Special diet / Dietary restrictions: _____

Social history

Your health sustaining activities or practices: _____

Occupation: _____ Main work activities: _____

Sources of stress: _____

I share my home with: _____

Exercise type: _____ Frequency: (circle) daily / ___ times weekly / rarely / never

Smoking status: (circle) never/past/current

Alcohol _____ drinks per day/week **Recreational Drug use** _____

Other providers

| | | |
|------------|-----------------|--------------|
| Name _____ | Specialty _____ | Clinic _____ |
| Name _____ | Specialty _____ | Clinic _____ |
| Name _____ | Specialty _____ | Clinic _____ |

Preferred pharmacy: _____



Review of systems

Constitutional symptoms

- Weight change
- Fever / chills
- Fatigue
- Spontaneous sweating
- Irregular/difficult sleep
- Night sweats

Eyes

- Glasses / contacts
- Blurred vision
- Eye pain
- Eye discharge
- Cataract
- glaucoma

Ears, Nose, Mouth, Throat

- Ringing in the ears (high/low pitch)
- Reduced hearing
- Post nasal drip
- Bleeding
- Nasal congestion (acute, chronic)
- Frequent ear infections
- Mouth sores
- Loss of taste
- Hoarseness

Cardiovascular (heart & vessels)

- Heart palpitations
- Chest pain
- Shortness of breath
- Ankle swelling
- Leg pain when walking

Respiratory

- Shortness of breath
- Wheezing
- Cough (wet / dry)

Gastrointestinal

- Appetite (decreased/increased)
- Abdominal pain
- Indigestion
- Nausea / vomiting
- Painful swallowing
- Hernia
- Blood in stool (red/black)
- Hemorrhoids
- Constipation
- Diarrhea
- Loose stools
- Anal discomfort
- Incontinence

Genitourinary

- Painful urination
- Wake to urinate
- Blood in urine
- Frequent urination
- Urgent urination
- Incontinence

Women

- PMS
- Menstrual migraine
- Irregular cycles
- Endometriosis
- Fibroids (current)
- Early menopause

Musculoskeletal

- Joint pain _____
- Muscle pain
- Swelling

Skin / breast

- Itching
- Rashes
- Hair/nail changes
- Breast masses
- Breast pain
- Nipple discharge

Neurological

- Headaches/migraines
- Tremor
- Fainting
- Weakness
- Numbness/tingling
- Walking/coordination difficulty
- Memory loss

Hormonal

- Hormone therapy
- Heat/cold intolerance
- Blood sugar imbalance

Blood

- Bleeding tendency
- History of transfusions
- Lymph node enlargement

Sexual history

- Gonorrhea
- Genital sores/discharge
- Chlamydia
- Herpes
- Pain with intercourse
- Prostate problems
- Testicular pain or swelling
- Erectile dysfunction

Trillium Natural Medicine

159 Wyatt Ave NE, Bainbridge Island WA 98110
(206) 304-8756 / www.trilliumnaturalmedicine.com



Past Medical History

Cardiovascular

- High Cholesterol
- Hypertension
- Abnormal heart rhythm
- Congestive heart failure
- Coronary artery disease
- Deep vein thrombosis (DVT)
- Heart attack (MI)
- Heart Valve Disease Deep vein thrombosis
- Phlebitis
- TIAs

Respiratory

- Asthma
- Bronchitis
- COPD
- Sarcoidosis
- Sleep Apnea
- TB

Digestive

- GERD (heartburn)
- Gall Stones
- Colon Polyps
- Crohn's Disease
- Ulcerative Colitis
- Pancreatitis
- Peptic Ulcer Disease
- Irritable Bowel Syndrome (IBS)
- Incontinence of Feces
- Hepatitis
- Cirrhosis

Allergy/Immune/Skin

- Seasonal allergies
- Eczema
- Psoriasis
- Acne

Urinary

- Benign Prostatic Hypertrophy
- Urinary Incontinence
- Infertility
- Kidney Failure
- Endometriosis
- Bed Wetting
- Erectile Dysfunction (Impotence)
- Glomerulonephritis
- Kidney Stones
- Frequent Bladder Infections

Musculoskeletal

- Chronic Pain
- Fibromyalgia
- Gout
- Juvenile Rheumatoid Arthritis
- Osgood-Schlatter Disease
- Osteoarthritis
- Rheumatoid Arthritis
- Systemic Lupus Erythematosus (SLE)
- Degenerative Disk Dz
- Other _____

Hormonal

- Diabetes
- Hypothyroid (low)
- Graves's disease
- Hashimotos

Infectious

- HIV
- Hepatitis A / B / C
- MRSA

Neurological

- Alzheimer's disease
- ADD/ADHD
- Autism
- Stroke
- Dementia
- Other _____
- Multiple Sclerosis
- Parkinson's
- Neuropathy
- Seizure disorder
- Other: _____

Hematologic

- Anemia _____
- Sickle Cell Disease

Psychiatric

- Anxiety
- Depression
- Bipolar
- Anorexia
- Bulimia
- Obsessive Compulsive
- Schizophrenia
- Other: _____

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