

Natural Medicine of NH, LLC

Lisa Klasman, ND

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Patient Note: This is a confidential record of your medical history. It will not be released except with your authorization. Please complete this questionnaire as thoroughly as possible. Mark anything you do not understand with a question mark. Thank you.

Date _____ Male Female SSN _____

Name _____ Nick Name _____

Address _____ DOB _____
Street
City State Zip Age _____

Phone _____ (home/cell/work) It's ok to leave message about my care

Email _____

Occupation _____

Employment Status: Full-time Part-time Student Retired Unemployed

Please circle: Married Divorced Single Widowed Significant Partnership

Live with: Spouse Partner Relatives Friends Alone Pets

Emergency Contact _____ Relation _____
Address _____ Phone _____

How did you hear about Dr. Klasman:

Referral/Friend _____

Yellow pages Lecture Walk or Drive-by Article Internet Other

What are your main health concerns?

1. _____
2. _____
3. _____
4. _____

Are you receiving health care from another practitioner? Y N

If yes, where and from whom?

Personal Habits:

Do you eat three meals per day? Y N Do you spend time outside? Y N
Do you drink coffee? Y N Do you drink sodas or energy drinks? Y N
Do you have a supportive relationship? Y N Do you take vacations? Y N
Religious or spiritual practice? Y N Do you enjoy your job? Y N
Have you had any major traumas? Y N
Do you have a history of abuse? Y N (physical, emotional or sexual)
Do you consume alcohol? Y N (Beer Wine Spirits) Number of drinks per day/week/month _____
Do you smoke? Y N Current or Past Yr started _____ Yr stopped _____
Do you now or have you ever used recreational drugs? Y N
Do you watch TV? Y N hrs per week _____ Do you read? Y N hrs per week _____

Sleep

Usual bedtime _____ hours slept _____
Problems with falling asleep or waking up after you fall asleep: Y N
Dreams and/or nightmares: Y N
Do you wake feeling rested Y N

Energy Level when waking up, throughout the day. (1 = low, 10 = high)

1 2 3 4 5 6 7 8 9 10

Exercise

How often do you exercise and what type of exercise?

Do you experience any symptoms during exercise (pain in any particular place in your body, shortness of breath, extreme fatigue beyond what is normal for the activity, heart palpitations, dizziness, abnormally high or low perspiration, etc.)?

What is your blood type? _____
Weight _____ Weight 1 year ago _____ Height _____
Maximum Weight _____ When? _____ What do you think is your ideal weight? _____

REVIEW OF SYSTEMS

Personal Medical History:

Please circle any of the following conditions/symptoms you have had,
Yes-I have this now; **Never**-I've never had it; **Past**-I've had it in the past but not now.

Head

Headaches	Y N P	Migraines	Y N P
Lightheadedness	Y N P	Dizziness	Y N P
Bell's Palsy	Y N P	Head injury or trauma	Y N P
Concussion	Y N P	Loss of balance	Y N P
Jaw/TMJ problems	Y N P	Other? _____	

Eyes

Spots in eyes Y N P
 Blurriness Y N P
 Double vision Y N P
 Swollen eyes Y N P
 Cataracts Y N P
 Tearing or dryness Y N P
 Night blindness Y N P
 Other _____

Impaired vision Y N P
 Color blindness Y N P
 Eye pain Y N P
 Eyestrain Y N P
 Glasses/contacts Y N P
 Glaucoma Y N P
 Circles under eyes Y N P

Ears

Impaired hearing Y N P
 Earaches Y N P
 Ringing in ears Y N P
 Frequent ear infections Y N P
 Other? _____

Deafness Y N P
 Itching of ears Y N P
 Excessive ear wax Y N P

Nose & Sinuses

Frequent colds Y N P
 Post nasal drips Y N P
 Nose bleeds Y N P
 Hayfever Y N P
 Polyps Y N P

Stuffiness Y N P
 Loss of Smell Y N P
 Sinus Problems Y N P
 Allergies Y N P
 Other? _____

Mouth & Throat

Frequent sore throat Y N P
 Hoarseness Y N P
 Loss of taste Y N P
 Sore lips Y N P
 Sore tongue Y N P
 Dental problems Y N P
 Dental cavities Y N P
 Copious saliva Y N P
 Other? _____

Sores in mouth Y N P
 Difficulty swallowing Y N P
 Teeth grinding Y N P
 Enlarged lymph nodes Y N P
 Gum problems Y N P
 Difficulty speaking Y N P
 Jaw clicks Y N P
 Dry mouth Y N P

Respiratory

Coughing Y N P
 Wheezing Y N P
 Pain with breathing Y N P
 Sputum Y N P
 Pleurisy Y N P
 Pneumonia Y N P
 Positive TB Test Y N P

Spitting up blood Y N P
 Difficulty breathing Y N P
 Shortness of breath Y N P
 Bronchitis Y N P
 Emphysema Y N P
 Asthma Y N P
 Other? _____

Cardiovascular

Heart disease Y N P
 Blood Clots Y N P
 Rheumatic Fever Y N P
 Bleeding/clotting disorder Y N P
 Atherosclerosis Y N P
 Heart murmurs Y N P
 Palpitations Y N P
 Chest Pain Y N P
 Heart attack Y N P
 Other? _____

High/Low blood pressure Y N P
 Phlebitis Y N P
 Swelling in ankles Y N P
 High cholesterol Y N P
 Angina Y N P
 Fainting Y N P
 Heart Flutters Y N P
 Stroke Y N P

Circulation

Cold hands/feet	Y	N	P	Deep leg pain	Y	N	P
Easy bleeding/bruising	Y	N	P	Varicose veins	Y	N	P
Thrombophlebitis	Y	N	P	Other? _____			

Gastrointestinal

Trouble swallowing	Y	N	P	Jaundice	Y	N	P
Nausea	Y	N	P	Vomiting blood	Y	N	P
Blood in stool	Y	N	P	Abdominal pain/cramps	Y	N	P
Belching or passing gas	Y	N	P	Gallbladder disease	Y	N	P
Ulcers	Y	N	P	Liver disease	Y	N	P
Hepatitis	Y	N	P	Heartburn	Y	N	P
Acid Reflux	Y	N	P	Change in appetite	Y	N	P
Diarrhea	Y	N	P	Constipation	Y	N	P
Bloating	Y	N	P	Stomach pain	Y	N	P
Black Stools	Y	N	P	Diverticulitis/losis	Y	N	P
Crohn's disease	Y	N	P	Irritable Bowel Syndrome	Y	N	P
Hemorrhoids	Y	N	P	Change in thirst	Y	N	P
Colitis	Y	N	P	Hiatal Hernia	Y	N	P
Vomiting	Y	N	P	Other? _____			

Frequency of bowel movements (number per day) _____

Quality of stools (small and hard, loose, etc.) _____

Urinary

Pain during urination	Y	N	P	Frequency at night	Y	N	P
Bladder infections	Y	N	P	Unable to urinate	Y	N	P
Increased frequency	Y	N	P	Unable to hold urine	Y	N	P
Kidney stones	Y	N	P	Blood in urine	Y	N	P
Other? _____							

Approximate number of times you urinate per day _____

Wake up at night to urinate: Y N Pain or other symptoms during urination. Y N

Skin

Rashes	Y	N	P	Hives	Y	N	P
Acne, boils	Y	N	P	Moles	Y	N	P
Lumps	Y	N	P	Ulceration	Y	N	P
Shingles	Y	N	P	Eczema	Y	N	P
Psoriasis	Y	N	P	Itching	Y	N	P
Dryness	Y	N	P	Perpetual hair loss	Y	N	P
Night sweats	Y	N	P	Sores	Y	N	P
Infections	Y	N	P	Change in hair/nails	Y	N	P
Other? _____							

Neck

Pain or stiffness	Y	N	P	Swollen Glands	Y	N	P
Pinched nerve	Y	N	P	Lumps	Y	N	P
Herniated disk	Y	N	P	Other? _____			

Musculoskeletal

Joint pain or stiffness	Y	N	P	Muscle spasms	Y	N	P
Muscle weakness	Y	N	P	Arthritis	Y	N	P
Bursitis	Y	N	P	Osteoporosis	Y	N	P
Osteopenia	Y	N	P	Broken Bones	Y	N	P
Back Pain	Y	N	P	Herniated disk	Y	N	P
Back surgery	Y	N	P	Other? _____			

Neurological

Seizures	Y	N	P	Muscle weakness	Y	N	P
Loss of memory	Y	N	P	Vertigo	Y	N	P
Dizziness	Y	N	P	Trembling hands/feet	Y	N	P
Mood swings	Y	N	P	Epilepsy	Y	N	P
Paralysis	Y	N	P	Numbness or tingling	Y	N	P
Loss of balance	Y	N	P	Lightheaded	Y	N	P
Poor concentration	Y	N	P	Slurred speech	Y	N	P
Neuralgia	Y	N	P	Loss of coordination	Y	N	P
Easily stressed	Y	N	P	Other? _____			

Mental / Emotional

Excess Stress	Y	N	P	Anxiety	Y	N	P
Panic Attacks	Y	N	P	Depression	Y	N	P
Mood swings	Y	N	P	Memory loss	Y	N	P
Suicidal thoughts	Y	N	P	Treated for emotions	Y	N	P
Nervousness	Y	N	P	Seasonal depression	Y	N	P
Other? _____							

Endocrine

Hypothyroid	Y	N	P	Hyperthyroid	Y	N	P
Hypoglycemia	Y	N	P	Excessive thirst	Y	N	P
Unexplained weight loss	Y	N	P	Fatigue	Y	N	P
Hormonal problems	Y	N	P	Heat or cold intolerance	Y	N	P
Diabetes	Y	N	P	Excessive hunger	Y	N	P
Easy weight gain	Y	N	P	Pituitary disorder	Y	N	P
Adrenal problem	Y	N	P	Other? _____			

Immune

Slow wound healing	Y	N	P	Chronic fatigue syndrome	Y	N	P
Chronic swollen glands	Y	N	P	Reaction to vaccinations	Y	N	P
Chronic infections	Y	N	P	Cancer	Y	N	P
Other? _____							

Infectious Illnesses

Scarlet Fever	Y	N	P	Diphtheria	Y	N	P
Rheumatic Fever	Y	N	P	Chicken Pox	Y	N	P
German Measles	Y	N	P	Mumps	Y	N	P
Measles	Y	N	P	Polio	Y	N	P
Meningitis	Y	N	P	Epstein-Barr	Y	N	P
Other? _____							

Female Reproductive History:**Menstruation**

Your age when you had your first menstrual period? _____

Are you past menopause? Y N

What was the date of the **start** of your most recent menstrual period? _____

How long do your periods last? _____ Are your cycles regular? Y N

How long is your cycle (from the start of one period to the start of the next)? _____

Do you use pads or tampons? _____

How many on heaviest day? _____

Do you experience cramps, pain or other symptoms **during your period**? If yes, please describe symptoms. _____

Pre-Menstrual Symptoms

Do you experience any of the following **prior to your menstrual period?**

Breast Tenderness Y N Bloating Y N Skin Problems Y N
 Mood Y N Changes Y N Headache Y N
 Cramping Y N Diarrhea Y N Appetite Changes Y N
 Low Back Pain Y N Constipation Y N Discharge (breast, vaginal) Y N

Do any of the above symptoms improve with the start of your flow?

Gynecological Conditions

Have you ever had recurring bladder or vaginal infections? Y N
 Have you ever had gynecological or breast surgery (including breast augmentation)?
 Current problems or past history of sexually transmitted disease/s?

Date of your last PAP? _____ Ever had an abnormal PAP? _____

Date of last mammogram? _____

Have you ever had any of the following conditions?

breasts: ___ discharge ___ tenderness ___ swelling ___ lumps ___ fibrocystic

Pelvic: ___ polycystic ovary disease ___ fibroids ___ cervical cancer

Sexual History

Are you currently sexually active? _____
 Do you experience pain or discomfort during sex? _____

Birth Control

___ none ___ hysterectomy ___ IUD (past/present) ___ Tubal ligation
 ___ Diaphragm (past/present) ___ oral contraceptive
 ___ condoms past present ___ patch / implant
 ___ partner vasectomy past present ___ other _____

Pregnancy History

pregnancies _____ Live births _____ miscarriages _____ abortions _____
 premature births _____

Family Medical History:

	Mother	Father	Brothers	Sisters	Children
Age (if living)					
Cancer					
Diabetes					
Heart Trouble					
High Blood Pressure					
Stroke					
Epilepsy					
Mental disorders					
Asthma					
Allergies					
Other conditions					
Age of Death					
Cause of Death					

Informed Consent

I acknowledge and understand that I have been informed and understand that: Any education, advice or health plans provided to me as a client of Natural Medicine of NH LLC are **not** to replace medical care that I am receiving from another licensed health care provider or medical doctor.

Natural Medicine of NH LLC strongly recommends that I am an active patient of a licensed primary care provider.

I agree to pay for any fees for service, costs of supplements, and remedies at time of service. Current fee schedule is as follows:

First Office Call, New Patient: Fee \$250

This fee covers the first time a patient is seen by Dr. Klasman. It includes pertinent physical exams, possible lab test to be ordered (fee for labs is separate) and is approximately one and one half hours in length.

Return Office Call: fee \$125

This fee covers successive appointments with Dr. Klasman. It is approximately one hour in length.

Missed Appointment: fee \$50

We do understand that there may be extenuating circumstances; however, we do require that any cancellation or change in your appointment be made 48 hours in advance. Patients that do not keep appointments or cancel with less than 48 hours notice will be charged a fee. This includes cancellation messages left on our answering machine after hours, a day or two before your appointment.

I have read the above information and consent to pay for services rendered at the time of service. I acknowledge that I may request the fees for various procedures and medications before they occur or are prescribed, and include that information in the decision regarding my healthcare. I consent to treatment as agreed upon between Dr. Klasman and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any concerns in my care with Dr. Klasman.

Signature _____ **Date:** _____
(Patient or Parent / Legal Guardian)

Print Name of patient _____