Natural Medicine of NH, LLC

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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.

Date _____ ☐ Male ☐ Female

Name _____ Nick Name _____

Address _____DOB _____
Street
_____ Age _____
City State Zip

Phone _____ (Mobile) ☐ It's ok to leave message about my care

Phone _____ (Home/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?

We care about your opinions and would like to know them regarding your health
How does your condition affect you?

What do you think is happening; why do you think you have this condition?

What do you feel needs to happen for you to get better?

How much change are you willing to make at this time for improving your health?
circle one: MINIMAL SOME COMPLETE

ALLERGIES
Are you allergic to any medications, herbs, foods, animals or any other substances not mentioned?

Substance	**Reaction**

PAST MEDICAL HISTORY (use back of page if necessary)

Surgeries and Hospitalizations (year, type, reason)

Other Significant Illnesses (i.e. mono, hepatitis, back injury)

Significant Childhood Health Issues

MEDICATIONS & SUPPLEMENTS (use back of page if necessary)

Drug or Supplement	Dose	When started	Reason taking

Personal Habits:

Do you eat three meals per day? Y N
Do you drink coffee? Y N
Do you have a supportive relationship? Y N
Religious or spiritual practice? Y N
Do you spend time outside? Y N
Do you drink sodas or energy drinks? Y N
Do you take vacations? 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	Impaired vision	Y	N	P
Blurriness	Y	N	P	Color blindness	Y	N	P
Double vision	Y	N	P	Eye pain	Y	N	P
Swollen eyes	Y	N	P	Eyestrain	Y	N	P
Cataracts	Y	N	P	Glasses/contacts	Y	N	P
Tearing or dryness	Y	N	P	Glaucoma	Y	N	P
Night blindness	Y	N	P	Circles under eyes	Y	N	P

Other _____

Ears

Impaired hearing	Y	N	P	Deafness	Y	N	P
Earaches	Y	N	P	Itching of ears	Y	N	P
Ringing in ears	Y	N	P	Excessive ear wax	Y	N	P
Frequent ear infections	Y	N	P				

Other? _____

Nose & Sinuses

Frequent colds	Y	N	P	Stuffiness	Y	N	P
Post nasal drips	Y	N	P	Loss of Smell	Y	N	P
Nose bleeds	Y	N	P	Sinus Problems	Y	N	P
Hayfever	Y	N	P	Allergies	Y	N	P
Polyps	Y	N	P	Other? _____			

Mouth & Throat

Frequent sore throat	Y	N	P	Sores in mouth	Y	N	P
Hoarseness	Y	N	P	Difficulty swallowing	Y	N	P
Loss of taste	Y	N	P	Teeth grinding	Y	N	P
Sore lips	Y	N	P	Enlarged lymph nodes	Y	N	P
Sore tongue	Y	N	P	Gum problems	Y	N	P
Dental problems	Y	N	P	Difficulty speaking	Y	N	P
Dental cavities	Y	N	P	Jaw clicks	Y	N	P
Copious saliva	Y	N	P	Dry mouth	Y	N	P

Other? _____

Respiratory

Coughing	Y	N	P	Spitting up blood	Y	N	P
Wheezing	Y	N	P	Difficulty breathing	Y	N	P
Pain with breathing	Y	N	P	Shortness of breath	Y	N	P
Sputum	Y	N	P	Bronchitis	Y	N	P
Pleurisy	Y	N	P	Emphysema	Y	N	P
Pneumonia	Y	N	P	Asthma	Y	N	P
Positive TB Test	Y	N	P	Other? _____			

Cardiovascular

Heart disease	Y	N	P	High/Low blood pressure	Y	N	P
Blood Clots	Y	N	P	Phlebitis	Y	N	P
Rheumatic Fever	Y	N	P	Swelling in ankles	Y	N	P
Bleeding/clotting disorder	Y	N	P	High cholesterol	Y	N	P
Atherosclerosis	Y	N	P	Angina	Y	N	P
Heart murmurs	Y	N	P	Fainting	Y	N	P
Palpitations	Y	N	P	Heart Flutters	Y	N	P
Chest Pain	Y	N	P	Stroke	Y	N	P
Heart attack	Y	N	P	Arrhythmia	Y	N	P

Other? _____

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/Osteopenia	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
Lyme Disease or other TBD	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 ____endometriosis

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								