

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 _____ Sex: Male Female Other _____

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?

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	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 (short/long)	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				Other? _____			

Male Reproductive System History:

Male Genitourinary

Urinary Frequency	Y N P	Urging without passing urine	Y N P
Waking during night to urinate	Y N P	Pain/burning	Y N P
Trouble starting urine	Y N P	Cloudy urine	Y N P
Red-tinged/blood urine	Y N P	Foul-smelling urine	Y N P
Prostate Cancer	Y N P	BPH	Y N P
Testicular cancer	Y N P	Penile cancer	Y N P
Pain or sores on penis	Y N P	Discharge from penis	Y N P
Hernias	Y N P	Testicular pain	Y N P
Testicular swelling	Y N P	Lumps on testicles	Y N P
Pain with ejaculation	Y N P	Other issues of scrotum/penis	Y N P
Premature ejaculation	Y N P		
Inability to achieve or maintain an erection	Y N P		
Surgery of prostate, genitals, hernia, vasectomy	Y N P		
Other? _____			

Sexual History

Are you currently sexually active? **YES NO** With men, women or both? _____

Do you have multiple partners? **YES NO**

Do you experience pain or discomfort during sex? **YES NO**

Do you use condoms or other birth control methods? **YES NO** _____

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					