BASIN
NATURAL MEDICINE
Transforming Health Naturally

Patient Health History

1.) When and where did you last receive health care?_____

For what reason?_____

2.) Do you have any medically diagnosed health conditions? (Y)(N)

If yes, please list:_____

3.) Please identify the health concerns that have brought you to Basin Natural Medicine, in order of importance below:

Condition **Past Treatment**

a)_____/ _____

How does this condition affect you?_____

b)_____/ _____

How does this condition affect you?_____

c)_____/ _____

How does this condition affect you?_____

d)_____/ _____

How does this condition affect you?_____

4.) Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

5.) If applicable please list any foods, drugs, or medications you are hypersensitive or allergic to:

_____

6.) Do you have any infectious diseases? ◯ yes ◯ no Please identify:_____

7.) Do you have any reason to believe you may be pregnant? ◯ yes ◯ no How far along?_____

8.) Height:_____ Weight (lbs)Currently: _____Past Maximum:_____ When?:_____

9.) Blood Pressure: What is your most recent blood pressure reading? ___/____: When was it taken?:_____

10.) **Hospitalizations and Surgeries:**

Reason:_____When?:_____Reason:_____When?:_____.

Reason:_____When?:_____Reason:_____When?:_____.

11.) **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason: _____When?:_____ Reason:_____When?:_____.

Reason:_____When?: _____Reason:_____When?:_____.

12.) **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

☐ Mood Swings ☐ Nervousness ☐ Mental Tension ☐ Depression ☐ Anxiety

13.) **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

☐ Fatigue ☐ Slow Wound Healing ☐ Chronic Infections ☐ Chronic Fatigue Syndrome

14.) **Head, Eye, Ear, Nose, and Throat** (please circle all that you experience now or any that you have experienced in the past):

☐ Impaired Vision ☐ Eye Pain/Strain ☐ Glaucoma ☐ Glasses/Contacts ☐ Tearing/Dryness

☐ Impaired Hearing ☐ Ear Ringing ☐ Earaches ☐ Headaches ☐ Sinus Problems

☐ Nose Bleeds ☐ Frequent Sore Throats ☐ Teeth Grinding ☐ TMJ/Jaw Problems ☐ Hay Fever

15.) **Respiratory** (please circle all that you experience now or any that you have experienced in the past):

☐ Pneumonia ☐ Frequent Common Colds ☐ Difficulty Breathing ☐ Emphysema

☐ Persistent Cough ☐ Pleurisy ☐ Asthma ☐ Tuberculosis ☐ Shortness of Breath

☐ Other Respiratory Problems:_____

16.) **Cardiovascular** (please circle all that you experience now or any that you have experienced in the past):

☐ Heart Disease ☐ Chest Pain ☐ Swelling of Ankles ☐ High Blood Pressure ☐ Palpitations/Fluttering

☐ Stroke ☐ Heart Murmurs ☐ Rheumatic Fever ☐ Varicose Veins

17.) Gastrointestinal (please circle all that you experience now or any that you have experienced in the past):

☐ Ulcers ☐ Changes in Appetite ☐ Nausea/Vomiting ☐ Stomach Pain ☐ Passing Gas ☐ Heartburn

☐ Belching ☐ Gall Bladder Disease ☐ Liver Disease ☐ Hepatitis B or C ☐ Hemorrhoids ☐ Abdominal Pain

18.) **Genito-Urinary Tract** (please circle all that you experience now or any that you have experienced in the past):

☐ Kidney Disease ☐ Painful Urination ☐ Frequent UTI ☐ Frequent Urination ☐ Heavy Flow

☐ Kidney Stones ☐ Impaired Urination ☐ Blood in Urine ☐ Frequent Urination at Night

19.) **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

☐ Irregular Cycles ☐ Breast Lumps/Tenderness ☐ Nipple Discharge ☐ Heavy Flow ☐ Vaginal Discharge

☐ Clotting ☐ Premenstrual Problems ☐ Bleeding Between Cycles ☐ Menopausal Symptoms

☐ Difficulty Conceiving ☐ Painful Periods

20.) Menstrual/Birthing History: (Women)

1. Age of First Menses:_____
2. # of Days of Menses: _____
3. Length of Cycle: _____
4. Birth Control Type: _____
5. # of Pregnancies: _____
6. # of Miscarriages: _____
7. # of Abortions: _____
8. # of Live Births: _____

21.) **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

☐ Sexual Difficulties ☐ Prostrate Problems ☐ Testicular Pain/Swelling ☐ Low Libido

22.) **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

☐ Neck/Shoulder Pain ☐ Muscle Spasms/Cramps ☐ Arm Pain ☐ Upper Back Pain ☐ Mid Back Pain

☐ Low Back Pain ☐ Leg Pain ☐ Joint Pain (If so where?)_____

23.) Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

☐ Vertigo/Dizziness ☐ Paralysis ☐ Numbness/Tingling ☐ Loss of Balance ☐ Seizures/Epilepsy

24.) **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

☐ Hypothyroid ☐ Hypoglycemia ☐ Hyperthyroid ☐ Diabetes ☐ Mellitus ☐ Night Sweats ☐ Feeling Hot or Cold

25.) **Other** (please circle any that you experience now and underline any that you have experienced in the past):

☐ Anemia ☐ Cancer ☐ Rashes ☐ Eczema/Hives ☐ Cold Hands/Feet

Is there anything else we should know?

_____

26.) **Lifestyle:**

a. Do you typically eat at least three meals per day? ◯ Yes ◯ No If no, how many?_____

b. Exercise routine:_____

c. Spiritual practice:_____

d. How many hours per night do you sleep?_____ Do you wake rested? ◯ Yes ◯ No

e. Have you experienced any major traumas? ◯ Yes ◯ No

Explain:_____

f. Nicotine/Alcohol/Caffeine/Marijuana Use:_____

g. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day?_____

h. Level of education completed: (High School) (Bachelors) (Masters) (Doctorate) Other:_____

i. Occupation:_____ Hours/Week:_____

Do you enjoy work? (Yes) (No) Why/Why not?_____

Thank You!

EMAIL FORM

PRINT FORM