The Spectrum Center for Natural Medicine
8555 16th Street, Suite 402 ● Silver Spring, MD 20910
301-565-2700 ● www.healingspectrum.com

Patient Health History

Please take the time to fill out the following questionnaire carefully. All of your information is confidential and will help us to better assist you toward more optimal health.

PATIENT INFORMATION

Name _____

Address _____

_____

Home Phone _____ Work Phone _____

Cell Phone _____ e mail _____

Today's Date _____ Birthday _____ Age _____

Occupation _____ Referred by _____

Family Physician _____ Phone _____

Height _____ Weight _____ (please circle) Married/Single/Divorced/Separated/Widowed/Partnered

Emergency Contact _____

Phone _____ Relationship _____

WHAT BRINGS YOU HERE

What health concerns bring you into our office for treatment? _____

_____

When did you first notice the symptoms? _____

Have you sought any other forms of treatment? _____

_____

LIFESTYLE HABITS

What, if any, form of exercise do you do regularly? _____

What does your diet consist of? _____

How often do you use any of the following each week? Cigarettes _____ Caffeine _____

Alcohol _____ Non-Prescription Drugs _____ Recreational Drugs _____

Please list all medications/herbs/vitamins/supplements you are currently taking:

_____

_____

The Spectrum Center for Natural Medicine
8555 16th Street, Suite 402 ● Silver Spring, MD 20910
301-565-2700 ● www.healingspectrum.com

MEDICAL HISTORY

Please complete the following table to the best of your knowledge. Include the date in the appropriate box when possible.

	self	mother	father	sibling	spouse	children
Allergies						
Asthma						
Blood Disorder						
Cancer						
Depression/Mental Illness						
Deceased (age)						
Diabetes						
Drug/Alcohol Abuse						
Heart Disease						
High Blood Pressure						
Hepatitus						
Kidney Disorder						
Musculoskeletal Disorder						
Throid Disorder						
Seizures						
Strokes						

Please write a "**C**" if the condition is current or a "**P**" if you have experienced the condition in the past:

GENERAL HEALTH

__Bleeding/bruising easily
__Change in appetite
__Chills
__Cravings
__Disturbed sleep
__Fever
__Insomnia
__Localized weakness
__Night sweats
__Poor appetite
__Poor balance
__Strong thirst
__Sudden energy drop
__Sweating easily
__Tremors
__Weight gain
__Weight loss

CARDIOVASCULAR

__Blood clots
__Chest pain
__Cold hands/feet
__Difficulty breathing
__Dizziness
__Fainting
__High blood pressure
__Irregular heartbeat
__Low blood pressure
__Phlebitis
__Swelling in hands/feet

GASTROINTESTINAL

__Abdominal pain/cramps
__Bad breath
__Belching
__Black stools
__Blood in stools
__Chronic laxative use
__Constipation
__Diarrhea
__Gas
__Hemorrhoids
__Indigestion
__Nausea
__Rectal pain
__Vomiting

GENITOURINARY

__Bedwetting
__Blood in urine
__Decreased libido
__Frequent urination
__Incomplete urination
__Increased libido
__Kidney stones
__Pain on urination
__Unable to hold urine
__Urgent urination
__Wake to urinate
__Other

HEAD/EYES/EARS/NOSE/THROAT

__Blurry vision
__Cataracts
__Color blindness
__Concussions
__Dizziness
__Earaches
__Eye pain
__Eye strain
__Facial pain
__Glasses
__Grinding teeth
__Headaches/migraines
__Jaw clicking
__Nose bleeds
__Poor hearing
__Poor vision
__Recurrent sore throats
__Ringing in ears
__Sinus problems
__Spots in front of eyes
__Teeth problems

INFECTION SCREENING (CIRCLE SELF AND/OR PARTNER)

__Chlamydia: self /partner
__Genital warts: self/partner
__Gonorrhea: self/partner
__Herpes: genital/oral: self/partner
__HIV: self/partner
__Syphilis: self/partner
__TB: self/household
__Other

MALE GENITAL

__Impotence
__Lumps in testicles
__Pain/itching of genitalia
__Premature ejaculation
__Nocturnal emission
__Other

MENTAL/EMOTIONAL

__Compulsive behavior
__Cry a lot
__Depression
__Difficultly focusing
__Difficulty relaxing
__Frustration
__Hopeless outlook
__Irritability
__Loneliness
__Lose temper
__Mood swings
__Sensitive
__Suicidal thoughts
__Worry a lot

MUSCULOSKELETAL

__Back pain
__Difficulty walking
__Joint pain
__Limited range of motion
__Muscle pain
__Muscle weakness
__Other

NEUROPSYCHOLOGICAL

__Anxiety
__Areas of numbness
__Bad temper
__Concussion
__Depression
__Dizziness
__Easily stressed
__Lack of coordination
__Loss of balance
__Poor memory
__Seizures
__Other

REPRODUCTIVE AND GYNECOLOGIC

__Abortions
__Heavy menstrual flow
__Irregular menses
__Light menstrual flow
__Menstrual clots
__Miscarriages
__Painful menses
__Premature births
__Premenstrual changes
__Unusual menses
__Other problems

Age at first menses_____Age at menopause_____Number of pregnancies_____
Time between cycles_____Duration of bleeding_____First day of last menses_____
Do you practice birth control?_____If yes, what type and for how long?_____

RESPIRATORY

__Asthma
__Bronchitis
__Cough
__Coughing up blood
__Difficulty breathing while lying down
__Pain with deep inhalation
__Pneumonia

SKIN AND HAIR

__Dandruff
__Eczema
__Hair loss
__Hives
__Itching
__Pimples
__Rashes
__Recent moles
__Ulcerations
__Changes in texture of hair or skin

Please list any other concerns or issues that you would like to discuss.

_____

_____

_____

Signature_____**Date**_____