

# The Spectrum Center for Natural Medicine

8555 16th Street, Suite 402 • Silver Spring, MD 20910  
301-565-2700 • www.healingspectrum.com

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## 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 \_\_\_\_\_ Email \_\_\_\_\_

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 \_\_\_\_\_

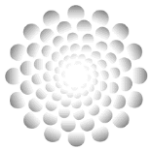
Alcohol \_\_\_\_\_ Non-Prescription Drugs \_\_\_\_\_ Recreational Drugs \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## 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						
Hepatitis						
Kidney Disorder						
Musculoskeletal Disorder						
Thyroid Disorder						
Seizures						
Strokes						

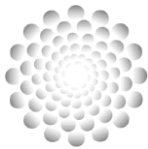
Please write a “C” if the condition is current or a “P” if you have experienced the condition in the past:

### GENERAL HEALTH

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Bleeding/bruising easily | <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Change in appetite       | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Sweating easily    |
| <input type="checkbox"/> Chills                   | <input type="checkbox"/> Night sweats       | <input type="checkbox"/> Tremors            |
| <input type="checkbox"/> Cravings                 | <input type="checkbox"/> Poor appetite      | <input type="checkbox"/> Weight gain        |
| <input type="checkbox"/> Disturbed sleep          | <input type="checkbox"/> Poor balance       | <input type="checkbox"/> Weight loss        |
| <input type="checkbox"/> Fever                    | <input type="checkbox"/> Strong thirst      |   |

### CARDIOVASCULAR

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Blood clots          | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Low blood pressure     |
| <input type="checkbox"/> Chest pain           | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Phlebitis              |
| <input type="checkbox"/> Cold hands/feet      | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swelling in hands/feet |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Irregular heartbeat |   |



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## GASTROINTESTINAL

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Abdominal pain/cramps | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad breath            | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Nausea      |
| <input type="checkbox"/> Belching              | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Black stools          | <input type="checkbox"/> Gas                  | <input type="checkbox"/> Vomiting    |
| <input type="checkbox"/> Blood in stools       | <input type="checkbox"/> Hemorrhoids          |                                      |

## GENITOURINARY

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Bedwetting         | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Unable to hold urine |
| <input type="checkbox"/> Blood in urine     | <input type="checkbox"/> Increased libido     | <input type="checkbox"/> Urgent urination     |
| <input type="checkbox"/> Decreased libido   | <input type="checkbox"/> Kidney stones        | <input type="checkbox"/> Wake to urinate      |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Pain on urination    | <input type="checkbox"/> Other                |

## HEAD / EYES / EARS / NOSE / THROAT

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Blurry vision   | <input type="checkbox"/> Eye strain          | <input type="checkbox"/> Poor hearing           |
| <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Facial pain         | <input type="checkbox"/> Poor vision            |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Glasses             | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Concussions     | <input type="checkbox"/> Grinding teeth      | <input type="checkbox"/> Ringing in ears        |
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Sinus problems         |
| <input type="checkbox"/> Earaches        | <input type="checkbox"/> Jaw clicking        | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Eye pain        | <input type="checkbox"/> Nose bleeds         | <input type="checkbox"/> Teeth problems         |

## INFECTION SCREENING ( CIRCLE SELF AND/OR PARTNER )

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Chlamydia: self /partner       | <input type="checkbox"/> Herpes: genital/oral:<br>self/partner | <input type="checkbox"/> Syphilis: self/partner |
| <input type="checkbox"/> Genital warts:<br>self/partner | <input type="checkbox"/> HIV: self/partner                     | <input type="checkbox"/> TB: self/household     |
| <input type="checkbox"/> Gonorrhea: self/partner        |  | <input type="checkbox"/> Other                  |

## MALE GENITAL

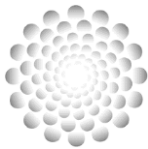
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Impotence          | <input type="checkbox"/> Pain/itching of genitalia | <input type="checkbox"/> Nocturnal emission |
| <input type="checkbox"/> Lumps in testicles | <input type="checkbox"/> Premature ejaculation     | <input type="checkbox"/> Other              |

## MENTAL/EMOTIONAL

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Compulsive behavior  | <input type="checkbox"/> Frustration      | <input type="checkbox"/> Mood swings       |
| <input type="checkbox"/> Cry a lot            | <input type="checkbox"/> Hopeless outlook | <input type="checkbox"/> Sensitive         |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Irritability     | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Difficultly focusing | <input type="checkbox"/> Loneliness       | <input type="checkbox"/> Worry a lot       |
| <input type="checkbox"/> Difficulty relaxing  | <input type="checkbox"/> Lose temper      |  |

## MUSCULOSKELETAL

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Back pain          | <input type="checkbox"/> Joint pain              | <input type="checkbox"/> Muscle pain     |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Muscle weakness |
|   |  | <input type="checkbox"/> Other           |



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## NEUROPSYCHOLOGICAL

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Depression           | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Poor memory     |
| <input type="checkbox"/> Bad temper        | <input type="checkbox"/> Easily stressed      | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Concussion        | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Other           |

## REPRODUCTIVE and GYNECOLOGIC

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abortions            | <input type="checkbox"/> Menstrual clots  | <input type="checkbox"/> Premenstrual changes |
| <input type="checkbox"/> Heavy menstrual flow | <input type="checkbox"/> Miscarriages     | <input type="checkbox"/> Unusual menses       |
| <input type="checkbox"/> Irregular menses     | <input type="checkbox"/> Painful menses   | <input type="checkbox"/> Other problems       |
| <input type="checkbox"/> Light menstrual flow | <input type="checkbox"/> Premature births |   |

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

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Coughing up blood                     | <input type="checkbox"/> Pain with deep inhalation |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty breathing while lying down | <input type="checkbox"/> Pneumonia                 |
| <input type="checkbox"/> Cough      |  |  |

## SKIN AND HAIR

- |                                    |                                       |   |
|------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Dandruff  | <input type="checkbox"/> Itching      | <input type="checkbox"/> Ulcerations                        |
| <input type="checkbox"/> Eczema    | <input type="checkbox"/> Pimples      | <input type="checkbox"/> Changes in texture of hair or skin |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Rashes       |   |
| <input type="checkbox"/> Hives     | <input type="checkbox"/> Recent moles |   |

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

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Signature \_\_\_\_\_ Date \_\_\_\_\_