In Health Naturopathic Medicine
CRYSTAL HANNAN, ND
4150 Pacific Ave, #300 - Forest Grove, OR 97116
Ph 503.357.3074 www.inhealthclinic.com

Confidential

HEALTH HISTORY

Patient Name:_____ Today's Date:_____
Age:_____ Birth date:_____ Day of Last Physical Examination:_____
What is the reason for your visit?:_____

Conditions

What, If any, serious conditions have you experienced in the past year?:_____

If there isn't enough space, please provide an attached list of all allergies, medications, and supplements.

Medications/Supplements

Medication Name	Dosage

Allergies

_____
_____
_____
_____
_____
_____

Pharmacy Name:_____ Phone: ( ) - _____

Symptoms

Check the box if you currently have or have had any of these symptoms in the past year:

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

GENITO/URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

SKIN
- ☐ Easy Bruising
- ☐ Hives/Itching
- ☐ Changes in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that don't heal

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Bloating/Gas
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea/Vomiting
- ☐ Rectal bleeding
- ☐ Stomach pain

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling in the ankles
- ☐ Varicose veins
- ☐ Other:_____

EYE/EAR/NOSE/THROAT
- ☐ Bleeding gums
- ☐ Blurred/double vision
- ☐ Difficulty swallowing
- ☐ Earaches
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Vision flashes/Halos

MEN ONLY
- ☐ Breast lumps
- ☐ Difficulty with erections
- ☐ Lump in testicles
- ☐ Sore penis
- ☐ Pain with intercourse
- ☐ Other: _____

WOMEN ONLY
- ☐ Abnormal PAP smear
- ☐ Bleeding between cycles
- ☐ Breast lumps
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Loss of Libido/sex drive
- ☐ Nipple discharge
- ☐ Vaginal dryness
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Vaginal pain
- ☐ Other: _____

Date of Last Menstrual Period: _____

Date of Last Pap: _____

Last Mammogram:_____

Are you Pregnant? _____
Number of Children:_____

FAMILY HISTORY; *Fill in health information about your immediate family*

Relation	Age	Gender	State of Health	Age At Death	Cause of Death	Check if, Your blood relative had any of the following		
Mother							Disease	Relationship to you
Father							Arthritis, Gout	
Siblings							Asthma, Hay Fever	
							Cancer	
							Chemical Dependency	
							Diabetes	
							Heart Disease, Stroke	
							High Blood Pressure	
							Kidney Disease	
							Tuberculosis	
							Other:	

IMPORTANT HOSPITALIZATIONS; *In the past 10 years*

Year	Hospital	Reason

PREGNANCIES; *Attach list if more than 5 births*

Year Of Birth	Sex of Birth	Complications, If Any

HEALTH HABITS

☒	Substance	How much
	Caffeine	
	Tobacco	
	Recreational Drugs	
	Alcohol	

OCCUPATIONAL

☒	Name Of Occupation:
	Stress
	Heavy lifting
	Hazardous Substances
	Other

Health Goals: Please take a moment to prioritize your concerns or goals for your health; be as specific as possible.

1. _____

2. _____

3. _____

I acknowledge and agree that I have read a copy of the physician's Notice of Privacy Practices and that a copy can be provided upon request. I also to my knowledge have filled out the above form with information that is accurate and complete. I understand that it is my responsibility to inform the physician in charge of my care if I ever have a change in health. _____initials

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient