

Hegnauer Holistic Health

Dr. Amanda Hegnauer

Naturopathic Doctor

Name _____ Date _____

Date of birth _____ Age _____ Height _____ Weight _____

Present Health Care Concerns: In your opinion, what are your most important health care concerns in their order of significance? Please indicate the concern that motivated you to come in today.

1) _____

2) _____

3) _____

4) _____

Health History: Mark all the sections that apply.

Health as a child? _____ Good _____ Fair _____ Poor

Childhood Illnesses? _____Scarlet Fever _____German Measles _____Measles _____Pertusis

_____Mononucleosis _____Polio _____Diabetes _____Rheumatic Fever _____Chicken Pox

_____Diphtheria _____Mumps _____Whooping Cough

_____Other _____

Were you breastfed as an infant? Y _____ N _____

Hospitalizations (year and reason) _____

Surgeries (year and reason) _____

Serious illness or injury (year and cause) _____

Vaccinations (year, type, adverse reaction?) _____

Medications: Include all supplements, prescription and non-prescription drugs and indicate name, dosage, how often taken and for how long:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Allergies: List any allergies you have to:

Drugs _____

Foods _____

Environmental _____

Animals _____

Other _____

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What happens when you have an allergy attack? _____

Habits: Substance use: For each please include approximate amount and for how long. If you have quit, please indicate past amount, duration of usage and when stopped.

Alcohol: _____ Y _____ N _____ Tobacco: _____ Y _____ N _____

Caffeine: _____ Y _____ N _____ Recreational Drugs: _____ Y _____ N _____

Diet: Any dietary restrictions or regimen? Describe _____

Are you satisfied with your diet now? Do you eat three meals a day? _____

Do you have any food cravings? What are they? _____

Do you sleep well? _____ Wake rested? _____ Average hours of sleep? _____

Enjoy your work? _____ Spend time outside? _____ How much time? _____

Exercise regularly? _____ What type of exercise? _____

How often? _____ How long? _____

Personal History: Currently (place a "C") or in the past (place a "P")

Abuse _____	Headaches _____	Skin Disease _____
Allergies _____	Heart Disease _____	Shortness of Breath _____
Arthritis _____	Hepatitis _____	Stomach/Intestinal Disorder _____
Back Injury _____	Hypertension _____	Tested Positive for HIV/AIDS _____
Chronic Constipation _____	Chronic Diarrhea _____	Contemplated Suicide _____
Depression _____	Physical Trauma _____	Sexually transmitted Infection _____

For Women:

Age of onset of Menses: _____ Frequency of Menses: _____

Flow: (circle one) Heavy Moderate Light

Pain with Menses: (circle one) Severe Moderate Light None

Date of last period: _____ Date of last Pap Smear: _____

Any history of abnormal Paps: (if yes please specify results, treatments and dates) _____

Are you sexually active? _____ Do you need help with birth control? _____

Type of Birth Control method used (if relevant) _____

Do you practice safe sex? _____

Pregnancies: _____ none _____ full-term _____ premature _____ miscarriages _____ abortions

Infertility? If yes, any work-ups, results and dates: _____

Vaginal Infections? Current, past, and type of symptoms: _____

Any PMS? If yes, timing of symptoms in relation to your menses and symptoms: _____

Any history of DES exposure? _____

Date of last mammogram and results: _____

Date of menopause, if relevant: _____

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Any problems associated with menopause? _____

For Men:

Date of last physical exam: _____

Date of last prostate exam: _____ Any concerns found? _____

Do you have any difficulty or pain with urination? _____

Do you ever have to get up at night to urinate? If so, how often? _____

Are you sexually active? _____ Do you practice safe sex? _____

Do you have any pain or difficulty with erection? _____ Ejaculation? _____

Any history of male infertility? (If yes, please give diagnosis and treatments tried) _____

For Men And Women:

Family History: Has any blood relative (mother (M), father (F), brother (B), sister (S), grandmother (GM), grandfather (GF), aunt (A), uncle (U), had any of the following conditions, in the past or present? Please indicate if relative is maternal or paternal, (ie. MGM: maternal grandmother, PU: paternal uncle).

<u>Condition</u>	<u>Relative</u>	<u>Condition</u>	<u>Relative</u>	<u>Condition</u>	<u>Relative</u>
Anemia _____		Arthritis _____		Asthma _____	
Allergies _____		Bleeding _____		Constipation _____	
Diabetes _____		Drugs/Alcohol _____		Eczema _____	
Genetic Disease _____		Glaucoma _____		Herpes _____	
Headaches _____		Heart Problem _____		Hypertension _____	
KidneyProblem _____		LiverProblem _____		MentalDisorder _____	
Osteoporosis _____		Seizure _____		SinusProblem _____	
StomachProblem _____		Stroke _____		Thyroid Disease _____	
Tuberculosis _____		VeneralDisease _____			
Cancer (specify type) _____					
Other _____					

<u>Relative</u>	<u>Heath Status</u>	<u>Age</u>	<u>If Deceased (cause of and age)</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Additional Notes:

