Hegnauer Holistic Health

Dr. Amanda Hegnauer, ND
Naturopathic Doctor

Name_____

Date_____

Date of birth_____ Age_____ Height _____ Weight_____

Address: _____
(Street, PO Box)

_____
(City) (State) (Zip Code)

Please Check Next To The Number To Call To Best Reach You:

___Home Phone: ( )_____ ___Day/Work: ( )_____ ___Cell ( )_____

Social Security#_____-_____-_____ Sex: M F Marital Status: M S D

E-Mail Address: _____

Name Of Primary Care Physician:_____

Name of Employer: _____

How Did You Hear About Us?_____
_____

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)_____
5)_____

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
_____Diptheria _____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 _____
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: _____

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).

Condition	**Relative**	**Condition**	**Relative**	**Condition**	**Relative**
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 _____

Relative	**Heath Status**	**Age**	**If Deceased (cause of and age)**
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Additional Notes:

_____
_____
_____
_____