**Hegnauer Holistic Health**
**Dr. Amanda Hegnauer, ND**
*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
_____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:**
_____
_____
_____
_____