Dr Elizabeth Collins
NATUROPATHIC PHYSICIAN

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PATIENT MEDICAL HISTORY

Today's Date	
Patient Name	Date of Birth
Parent/Guardian if Applicable	

PAST MEDICAL INFORMATION

When and where did you last receive healthcare?
What was the reason?

CURRENT MEDICAL INFORMATION

Please list your concerns for your physical, emotional, or mental health in order of importance:

1.
2.

IMMUNIZATION HISTORY

POLIO	Y	N	Date	HEPATITIS A	Y	N	Date
DIPTHERIA	Y	N	Date	HEPATITIS B	Y	N	Date
TETANUS	Y	N	Date	VARICELLA	Y	N	Date
PERTUSSIS/WHOOPING COUGH HIB	Y	N	Date	MMR	Y	N	Date

ALLERGIES

What drugs are you allergic to?

Drugs

What foods are you allergic to?

Foods

What environmental allergies/sensitivities affect you?

Environment

HOSPITALIZATIONS Please list age/purpose/treatement rendered

Age	Purpose	Treatment/Surgery
Age	Purpose	Treatment/Surgery
Age	Purpose	Treatment/Surgery

CURRENT MEDICATIONS OR SUPPLEMENTS Please list names and amounts

TRAVEL Please list where you have travelled and your age at the time of travel

Age	Destination
Age	Destination
Age	Destination

LIFESTYLE & DIET - Y=Yes, currently; N=Never; P=In the past

Water	Y N P	Amount		Marijuana	Y N P	Amount	
Soft Drinks/Soda	Y N P	Amount		Cocaine	Y N P	Amount	
Coffee	Y N P	Amount		Other	Y N P	Amount	
Alcohol	Y N P	Amount		Exercise	Y N P	Amount	
Cigarettes	Y N P	Amount		Sleep	Number of hours	Amount	

FAMILY HISTORY - Please indicate which family member and any details

Alcoholism		Glaucoma	
Anemia		Heart Diseas	
Arthritis		High Blood Pressure	
Asthma		Kidney Disease	
Cancer		Mental Illness	
Diabetes		Stroke	
Drug Addiction		Thyroid Problems	
Eczema/Psioriasis		Tuberculosis	

PERSONAL MEDICAL HISTORY (Y=Yes, currently; N=Never; P=In the past

Skin				Respiratory				Cardiovascular			
Acne	Y	N	P	Asthma	Y	N	P	Heart disease	Y	N	P
Rashes	Y	N	P	Cough	Y	N	P	Murmurs	Y	N	P
Eczema	Y	N	P	Pneumonia	Y	N	P	Palpitations	Y	N	P
Moles	Y	N	P	Bronchitis	Y	N	P	Chest pain	Y	N	P
				Shortness of breath	Y	N	P	High blood pressure	Y	N	P
EENT				Wheezing	Y	N	P	Anemia	Y	N	P
Dry eyes	Y	N	P								
Impaired vision	Y	N	P	**Extremities**				**Female reproductive**			
Eye discharge	Y	N	P	Blood clots	Y	N	P	Irregular cycle	Y	N	P
Eachaches	Y	N	P	Restless legs	Y	N	P	Painful menses	Y	N	P
Hearing difficulty	Y	N	P	Varicose veins	Y	N	P	Infections	Y	N	P
Ringing in ears	Y	N	P	Cold hands and feet	Y	N	P	Heavy menses	Y	N	P
Frequent colds	Y	N	P					Menopause	Y	N	P
Nosebleeds	Y	N	P	**Endocrine**				Painful intercourse	Y	N	P
Nasal congestion	Y	N	P	Thyroid problems	Y	N	P	Infertility	Y	N	P
Hayfever	Y	N	P	Diabetes	Y	N	P	#pregnancies	Y	N	P
Hoarseness	Y	N	P	Fatigue	Y	N	P	Breast lumps/pain	Y	N	P
Bleeding gums	Y	N	P								
Difficulty swallowing	Y	N	P	**Neurological**				**Male reproductive**			
Sore throat	Y	N	P	Seizures	Y	N	P	Testicular pain	Y	N	P
				Numbness/tingling	Y	N	P	Infection	Y	N	P
Gastrointestinal				Memory loss	Y	N	P	Prostate pain	Y	N	P
Heartburn/indigestion	Y	N	P	Paralysis	Y	N	P	Hernia	Y	N	P
Belching/gas	Y	N	P	Headaches	Y	N	P				
Vomiting	Y	N	P	Head injury	Y	N	P	**Mental emotional**			
Constipation	Y	N	P					Anxiety	Y	N	P
Diarrhea	Y	N	P	**Urinary system**				Depression	Y	N	P
Change in appetite	Y	N	P	Incontinence	Y	N	P	Excessive fears	Y	N	P
Hemorrhoids	Y	N	P	Kidney stones	Y	N	P	Mood swings	Y	N	P
Gallbladder disease	Y	N	P	Bladder infections	Y	N	P	Weeping	Y	N	P

Signature _____ *Date* _____

Printed Name _____