Guided Health, PC.

1421 SE 50th Avenue

Portland, OR 97215

503-260-0116

PATIENT HISTORY

Name:____ Date: ____________________
(first) (middle) (last)

Street Address: ____

City: ______________________________ State:____________________ Zip: ____________________

Home Telephone: ______________________________ Work Telephone: ______________________________

Date of Birth: ____________________ Gender: ________________ Social Security: __________ - ________ - __________

Emergency Contact: ________________________ Telephone: ________________ Relationship:________________

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient – physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark (?). Thank you.

● Are you currently receiving health care? **Y** **N**

If YES, from where and from whom? ____

If NO, when and where did you last receive health care? ________________________________

And for what reason? ____

● Please identify the health concerns that have brought you here today:

CONDITION PAST TREATMENT

a. ______________________________ ______________________________

How does this condition affect you? ____

b. ______________________________ ______________________________

How does this condition affect you? ____

c. ______________________________ ______________________________

How does this condition affect you? ____

d. ______________________________ ______________________________

How does this condition affect you? ____

● What are you most important health problems? Please list in order of importance:

a. ______________________________ b. ______________________________

c. ______________________________ d. ______________________________

● Is there any possibility that you may be pregnant? **Y** **N**

● Do you have chronic infectious diseases? **Y** **N** If yes, please explain: ______________________________

● Do you currently suffer from any chronic illnesses? **Y** **N** If yes, please explain: ________________________

____

● Please list any food, drugs, or medications to which to which you are hypersensitive or allergic (please include the type of reaction):

____

____

● Please list any prescription medications, over-the-counter medications, vitamins, and supplements that you currently take:

____

____

____

- Nicotine/Alcohol/Caffeine/Substance Use: ____
- Have you had any recent or significant changes in height and/or weight? ______________________
- Blood Pressure: What was most recent blood pressure reading? ________/______ When was this reading taken? ______________
- Childhood illnesses (please circle any you may have had): Scarlet Fever Diphtheria Rheumatic Fever Mumps Polio Measles German Measles Chicken Pox Other: ______________________________
- Immunizations (please circle any you may have had):
  Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Other: ______________________
- Hospitalizations and Surgeries:
  Reason: ____ Date: ________________
  Reason: ____ Date: ________________
  Reason: ____ Date: ________________
  Reason: ____ Date: ________________
- X-Rays / CAT Scans / MRI's / Imaging Special Studies:
  Reason: ____ Date(s):______________
  Reason: ____ Date(s): ______________

Family History:	**Mother**	**Father**	**Brothers**	**Sisters**	**Children**
Age (if living):	______	______	______	______	______
Age at death:	______	______	______	______	______
Cause of death:	______	______	______	______	______

Please describe your habits/preferences regarding meals:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Consumption of liquids: ____

Daily Activities/Hobbies/Exercise: ____

____

Occupation/Work Activities: ____

Possible Sources of Stress: ____

What do you do to relax/nurture your self ? ______________________________

Sleep Habits: ____

Have you experienced any major traumas? __________ Please explain: ______________________

____

Do you have a spiritual foundation in your life? Y / N

How would you rate your self love? Low 1 2 3 4 5 6 High

Please review and check the boxes that apply to you by marking Yes/No and check the "Family" box if relevant to family members:

Yes	No	Family		Yes	No	Family		Yes	No	Family	
☐	☐	☐	Impaired Vision	☐	☐	☐	Eye Pain/Strain	☐	☐	☐	Glaucoma
☐	☐	☐	Tearing/Dryness	☐	☐	☐	Impaired Hearing	☐	☐	☐	Ear Ringing/Tinnitus
☐	☐	☐	Ear Aches/Sensitivity	☐	☐	☐	Headaches	☐	☐	☐	Migraines
☐	☐	☐	Nose Bleeds	☐	☐	☐	Frequent Sore Throat	☐	☐	☐	Sinus Problems
☐	☐	☐	Teeth Grinding	☐	☐	☐	Jaw Problems/TMJ	☐	☐	☐	Hay Fever/Allergies
☐	☐	☐	Vertigo/Dizziness	☐	☐	☐	Paralysis	☐	☐	☐	Numbness/Tingling
☐	☐	☐	Loss of Balance	☐	☐	☐	Seizures/Epilepsy	☐	☐	☐	Nervousness
☐	☐	☐	Mental Tension	☐	☐	☐	Fatigue	☐	☐	☐	Slow Wound Healing
☐	☐	☐	Chronic Infections	☐	☐	☐	Neck Pain	☐	☐	☐	Shoulder Pain
☐	☐	☐	Upper Back Pain	☐	☐	☐	Mid-Back Pain	☐	☐	☐	Lower Back Pain
☐	☐	☐	Arm Pain	☐	☐	☐	Leg Pain	☐	☐	☐	Hand/Foot Pain
☐	☐	☐	Joint Pain	☐	☐	☐	Muscle Spasms	☐	☐	☐	Muscle Weakness
☐	☐	☐	Frequent Colds	☐	☐	☐	Difficulty Breathing	☐	☐	☐	Shortness of Breath
☐	☐	☐	Persistent Cough	☐	☐	☐	COPD	☐	☐	☐	Asthma
☐	☐	☐	Emphysema	☐	☐	☐	Pneumonia	☐	☐	☐	Pleurisy
☐	☐	☐	Tuberculosis	☐	☐	☐	Chest Pain	☐	☐	☐	Heart Disease
☐	☐	☐	High Blood Pressure	☐	☐	☐	Low Blood Pressure	☐	☐	☐	Clotting Problems
☐	☐	☐	High Cholesterol	☐	☐	☐	Stroke	☐	☐	☐	Palpitations
☐	☐	☐	Murmur/Irregular Beat	☐	☐	☐	Varicose Veins	☐	☐	☐	Swelling/Edema
☐	☐	☐	Coronary Artery Disease	☐	☐	☐	Vascular Disease	☐	☐	☐	Aneurysm
☐	☐	☐	Changes in Appetite	☐	☐	☐	Nausea/Vomiting	☐	☐	☐	Abdominal Pain
☐	☐	☐	Heartburn	☐	☐	☐	Belching/Gas	☐	☐	☐	Ulcers
☐	☐	☐	Gall Bladder Disease	☐	☐	☐	Liver Disease	☐	☐	☐	Hepatitis
☐	☐	☐	Hemorrhoids	☐	☐	☐	Blood in Stool	☐	☐	☐	Coughing/Vomiting Blood
☐	☐	☐	Undigested Food in Stool	☐	☐	☐	Mucous	☐	☐	☐	Diarrhea
☐	☐	☐	Constipation	☐	☐	☐	Incontinence	☐	☐	☐	Painful Urination
☐	☐	☐	Blood in Urine	☐	☐	☐	Impaired Urination	☐	☐	☐	Frequent Urination
☐	☐	☐	Urinary Tract Infections	☐	☐	☐	Kidney Disease	☐	☐	☐	Kidney Stones
☐	☐	☐	STD's	☐	☐	☐	Irregular Cycles	☐	☐	☐	Bleeding between Cycles
☐	☐	☐	Menopausal Symptoms	☐	☐	☐	Breast Lump/Tenderness	☐	☐	☐	Nipple Discharge
☐	☐	☐	Vaginal Discharge	☐	☐	☐	Clots in Menses	☐	☐	☐	Heavy Flow
☐	☐	☐	Premenstrual Tension	☐	☐	☐	Cramps/Pain	☐	☐	☐	Difficulty Conceiving
☐	☐	☐	Sexuality Difficulties	☐	☐	☐	Prostate Problems	☐	☐	☐	Testicular Pain/Swelling
☐	☐	☐	Penile Discharge	☐	☐	☐	Penile Pain	☐	☐	☐	Cancer
☐	☐	☐	Anemia	☐	☐	☐	Rashes	☐	☐	☐	Cold Hands/Feet
☐	☐	☐	Hypothyroid	☐	☐	☐	Hyperthyroid	☐	☐	☐	Hypoglycemia
☐	☐	☐	Diabetes	☐	☐	☐	Night Sweats	☐	☐	☐	Adrenal Disorders
☐	☐	☐	Post traumatic stress	☐	☐	☐	Dissociation	☐	☐	☐	Panic/Anxiety Attacks
☐	☐	☐	Chronic Stress	☐	☐	☐	Paranormal Experiences	☐	☐	☐	Sense of something missing
☐	☐	☐	Sleep Disorders	☐	☐	☐	Mood Swings				

Do you have any other health issues or concerns? ____

____

What would you like to have different in your life? ____

____