Foothills Neurology
Naturopathic HEALTH HISTORY
Dr. Timothy J. Visser, ND

Name:_____ Birthdate: _____
Date:_____/_____/_____

GENERAL

Place of birth	Education
Relationship status	Occupation
Exercise/recreation	Height
Weight	
Date of last Physical Exam	Date of last Eye exam
Date of last colonoscopy	Date of last Prostate exam
Date of last full bloodwork	Date of last Bone Density testing
Date of last Mammogram	Date of last Dental Exam
Describe all serious accidents, severe injuries, head injury, fractures or broken abones (include date occurred): ☐ None	List all serious illnesses, operations, and other operations, and other hospitalizations you have experienced and indicate year these occurred: ☐ None

CHIEF COMPLAINTS: Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

1._____ 4._____
2._____ 5._____
3._____ 6._____

MEDICATION (Include everything you have taken or are taking: pills, tablets, liquids, ointments, suppositories, etc)

Medication	Dose	Reason

VITAMINS, MINERALS, HERBS

Supplement	Brand	Dose	Reason

ALLERGIES:
Drugs:
Foods:
Environmental Sources:
Other:

PAST MEDICAL HISTORY

Measles	no	yes	Hernia	no	yes
Hives or Eczema	no	yes	Thyroid Disease	no	yes
Mumps	no	yes	Blood Transfusions	no	yes
Tuberculosis	no	yes	Kidney Disease	no	yes
Infectious Mono	no	yes	AIDs or HIV+	no	yes
Chickenpox	no	yes	Heart Disease	no	yes
Diabetes	no	yes	Bleeding tendency	no	yes
Rheumatic Fever	no	yes	High Blood Pressure	no	yes
Whooping Cough	no	yes	High Cholesterol	no	yes
Cancer	no	yes	Anemia	no	yes
Mitral Valve Prolapse	no	yes	STD's	no	yes
Scarlet Fever	no	yes	Any other disease (please list)		
Polio	no	yes	_____		
Stroke	no	yes	_____		
Glaucoma	no	yes	_____		
Hepatitis	no	yes			
Smallpox	no	yes			

FAMILY HISTORY:

	Who		Who
Alcohol or Drug Problem		HIV	
Allergies		Kidney Disease	
Anemia		Leukemia	
Ankylosing Spondilitis		Mental Illness	
Asthma		Migraine Headaches	
Autoimmune disorders		Multiple Sclerosis	
Cancer		Muscular Dystrophy	
Chronic Lung Disease		Obesity	
Diabetes		Osteoporosis	
Eczema		Psoriasis	
Epilepsy		Rheumatoid Arthritis	
Glaucoma		Stroke	
Gout		Thyroid Disease	
Heart Disease		Tuberculosis	
Hepatitis		Ulcers	
High Blood Pressure		Other	
High Cholesterol			

REVIEW OF SYSTEMS

Please check any of the following conditions which apply to you currently.

SKIN

- ☐ **Rashes**
- ☐ **Jaundice**
- ☐ **Dry skin**
- ☐ **Shingles**
- ☐ **Acne**
- ☐ **Bruising easily**
- ☐ **Hives**
- ☐ **Lesions (cuts take a long time to heal)**
- ☐ **Eczema**
- ☐ **Ringworm**
- ☐ **Excessive perspiration**
- ☐ **Bumpy skin on back of arms**
- ☐ **Changes in hair/ nails**
- ☐ **Psoriasis**
- ☐ **Athletes foot**
- ☐ **Body odor**

HEAD

- ☐ **Hair loss/thinning**
- ☐ **Headache**
- ☐ **Dry coarse hair**
- ☐ **Migraines**
- ☐ **Head injury**

EYES

- ☐ Itchy eyes
- ☐ Eyes sensitive to light
- ☐ Double vision
- ☐ Dry eyes
- ☐ Floaters
- ☐ Red or inflamed eyes
- ☐ Eye pain
- ☐ Discharge from eyes
- ☐ Styes
- ☐ Lasix or corrective surgery
- ☐ Impaired vision
- ☐ Blurred vision
- ☐ Watery eyes
- ☐ Puffiness/dark circles under eyes

EARS

- ☐ Impaired hearing
- ☐ Wax in the ears
- ☐ Itchy ears
- ☐ Ringing in the ears
- ☐ Ear Pain
- ☐ Ear discharge or ears stuffed up
- ☐ Earache
- ☐ Ear infections

NOSE & SINUSES

- ☐ Frequent colds
- ☐ Nasal congestion
- ☐ Loss of smell
- ☐ Post nasal drip
- ☐ Sinus problems
- ☐ Itchy nose
- ☐ Nose bleeds
- ☐ Breathe through mouth
- ☐ Allergies

MOUTH & THROAT

- ☐ Frequent sore throat
- ☐ Hoarseness
- ☐ Inflamed/bleeding gums
- ☐ Difficulty swallowing
- ☐ Dry mouth
- ☐ Throat infections
- ☐ Sores in mouth/on lips
- ☐ Dental / Gum problems
- ☐ Loss of taste
- ☐ Crack in corners of mouth
- ☐ Mucous in throat
- ☐ Dentures
- ☐ Swollen tongue
- ☐ Itchy mouth or throat
- ☐ Chapped lips

RESPIRATORY

- ☐ Chronic cough
- ☐ Smoker
- ☐ Lung congestion
- ☐ Wheezing / Asthma
- ☐ Coughing up blood/phlegm
- ☐ Exposed to chemicals/radiation
- ☐ Sensitive to smog/pollution
- ☐ Positive TB test ever?
- ☐ Bronchitis/Pneumonia
- ☐ Live/work with people who smoke
- ☐ Difficulty or pain with breathing
- ☐ Shortness of breath

HEART

- ☐ Heart Disease
- ☐ Chest pain
- ☐ Rapid beating heart
- ☐ Chest tightness
- ☐ Heaviness in legs
- ☐ Swelling in ankles
- ☐ Dizziness upon standing
- ☐ High Blood pressure
- ☐ Do you do aerobic exercise
- ☐ Calf muscles cramp while walking
- ☐ Drink >5 cups of coffee/day
- ☐ Difficulty breathing at night
- ☐ MVP
- ☐ Low Blood pressure
- ☐ Exhaustion with minor exertion
- ☐ Heart Fluttering
- ☐ High cholesterol
- ☐ Severe cough
- ☐ Heart Murmur

CIRCULATION

- ☐ Deep leg pain
- ☐ Purple fingers or lips
- ☐ Cold hands/feet
- ☐ Varicose veins

BLOOD

- ☐ Anemia
- ☐ Easy bleeding
- ☐ Easy bruising

DIGESTION

- ☐ Mucous in stools
- ☐ Heartburn / Antacid use
- ☐ Stomach upset/pain
- ☐ Indigestion
- ☐ Foul smelly stools
- ☐ Ulcers
- ☐ Change in appetite
- ☐ Fatigue after eating
- ☐ Floating stool
- ☐ Constipation (< 1 bm/day)
- ☐ 4 or more BM's per day
- ☐ Belching or burping
- ☐ Liver/Gall Bladder disease
- ☐ Hemorrhoids
- ☐ Blood in stools
- ☐ Black tarry stools
- ☐ Food sensitivity
- ☐ Feeling of incomplete bowel movement
- ☐ Trouble swallowing
- ☐ Intolerance to greasy foods
- ☐ Loose Stools or Diarrhea
- ☐ Relief of pain by drinking milk
- ☐ Bad breath / Body odor
- ☐ Gas, Bloating
- ☐ Nausea or Vomiting
- ☐ Undigested food in stool

DIET: *please list typical foods consumed on a regular basis*

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Fluids:_____
Alcohol:_____

DO YOU DRINK OR CONSUME:

Alcohol	Candy	Carbonated beverages	Cheese
Cigarettes	Coffee	Meals at fast food restaurants	Fried foods
Luncheon meats	Margarine	Meat eater	Milk or Ice Cream
Refined sugar	Saccharine or Aspartame	Chew tobacco	Butter

URINARY

- ☐ Frequent urination
- ☐ Inability to hold urine
- ☐ Can't hold urine
- ☐ Cloudy urine
- ☐ Dark urine
- ☐ Bedwetting
- ☐ Frequent vaginal infections
- ☐ Rarely need to urinate
- ☐ Painful/burning when urinating
- ☐ Rose colored (bloody) urine
- ☐ Kidney or bladder infections
- ☐ Urination at night
- ☐ Urination cough or sneeze
- ☐ Dripping after urination
- ☐ Strong smelling urine
- ☐ Antibiotics for urinary infections

NEUROLOGIC

- ☐ Fainting
- ☐ Muscle weakness
- ☐ Poor concentration
- ☐ Loss of balance
- ☐ Head feels heavy
- ☐ Trembling in hands
- ☐ Loss of grip strength
- ☐ Seizures / Convulsions
- ☐ Numbness or tingling
- ☐ Ringing in ears
- ☐ Dizziness or Vertigo
- ☐ Headache / Migraine
- ☐ Loss of feeling in hands/feet/toes
- ☐ Paralysis
- ☐ Loss of memory
- ☐ Need for 10-12 hours sleep
- ☐ Lack of mental alertness
- ☐ Loss of muscle tone
- ☐ Uncoordinated

ENERGY & SLEEP

- ☐ Chronic fatigue
- ☐ Feel tired in afternoon
- ☐ Need coffee to get started
- ☐ Take medications for sleep
- ☐ Can't fall asleep
- ☐ Intense dreams or Nightmares
- ☐ Restless / uneasy sleeper
- ☐ Wake up middle of night

ENDOCRINE

- ☐ Night sweats
- ☐ Excessive hunger
- ☐ Boils and leg sores
- ☐ Overweight
- ☐ Failing eyesight
- ☐ Crave sweets
- ☐ Swollen eyes (bulging)
- ☐ Depressed / apathetic
- ☐ Any thyroid problems
- ☐ Gain weight easily
- ☐ Headaches relieved by eating
- ☐ Dizziness upon standing
- ☐ Calmer after eating
- ☐ Feel tired after eating
- ☐ Hypoglycemia
- ☐ Strong smelling urine
- ☐ Feel tired/weak if meal is missed
- ☐ Cuts take a long time to heal
- ☐ Sugar in urine
- ☐ Dry skin
- ☐ PMS or heavy bleeding
- ☐ Trouble waking up in morning
- ☐ Heat or cold intolerance
- ☐ Temperature below 98.6
- ☐ Irritable if a meal is missed
- ☐ Awaken at night hungry
- ☐ Excessive thirst
- ☐ Lowered resistance to infection
- ☐ Menstrual irregularities
- ☐ Feel energized from exercise
- ☐ Family history of Diabetes
- ☐ Thick skin and fingernails
- ☐ Impatient/moody/nervous/anxious
- ☐ Low sex drive
- ☐ Thinning outside of eyebrows
- ☐ Fatigue
- ☐ Infertility
- ☐ Feel shaky or jittery
- ☐ Heart palpitations after eating

MALE REPRODUCTION

- ☐ Difficulty urinating
- ☐ Low sperm count
- ☐ Dripping after urination
- ☐ Ejaculation causes pain
- ☐ Premature ejaculation
- ☐ Infertile
- ☐ Prostate problems
- ☐ A sense of bladder fullness
- ☐ Pain or burning while urinating
- ☐ Pain/fatigue in back
- ☐ Sexual difficulties
- ☐ Pain/coldness in genital area
- ☐ Rose colored (bloody) urine
- ☐ Sexually transmitted diseases
- ☐ Discharge from penis
- ☐ Wake up to urinate at night
- ☐ Lack of sex drive
- ☐ Testicular lump or pain
- ☐ Sores on penis
- ☐ Hernias

FEMALE REPRODUCTION

Pregnancies ____ Births ____ Miscarriages ____ Abortions ____

Date of Last Menstrual cycle___/___/___ Days Between Cycles _____ Ususal Length of cycle ____days

Age menses began _____ Are cycles regular? _____ Date of last pap smear___/___/___

Do you take any Hormone Replacement therapy or Birth Control? If so, what kind? _____
Have you used Hormone replacement in the past? Y N If yes, what kind and for how long? _____
Have you taken Hormonal Birth Control in the past? Y N If yes, for how long? _____

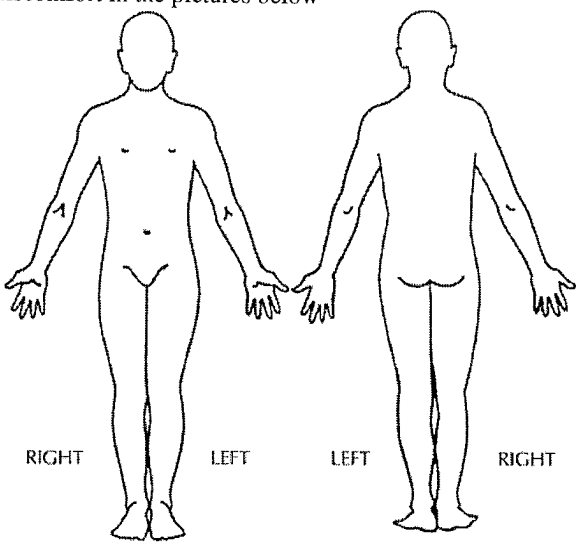
- ☐ Monthly weight gain
- ☐ Nausea and/or vomiting
- ☐ Headaches
- ☐ Tender Breasts
- ☐ Pain during intercourse
- ☐ Difficulty conceiving
- ☐ Night sweats
- ☐ Osteoporosis
- ☐ Ovarian cysts
- ☐ Hysterectomy
- ☐ Depression Moodiness/irritability
- ☐ Anxiety
- ☐ Suicidal feelings
- ☐ Low backache
- ☐ Vaginal discharge
- ☐ Vaginal yeast infections
- ☐ Hot flashes
- ☐ Increased urinary frequency
- ☐ Uterine cysts / fibroids
- ☐ Infertility
- ☐ Bloating and swelling
- ☐ Leg cramps and tenderness
- ☐ Low abdominal pain/cramping
- ☐ Bleeding between periods
- ☐ Excessive flow
- ☐ Light blood flow
- ☐ Sexually transmitted diseases
- ☐ Vaginal itching
- ☐ Low or no desire for sex

MUSCULOSKELETAL

- ☐ Pain in fingers
- ☐ Chronic pain
- ☐ Joint pain or stiffness
- ☐ Calcium deposits
- ☐ Herniated / slipped disc
- ☐ Injure easily
- ☐ Pain in arms / hands
- ☐ Loss in height
- ☐ Double-jointed
- ☐ Bones sore/painful
- ☐ Arthritis
- ☐ Bone deformity
- ☐ Stiff in morning
- ☐ Broken bones
- ☐ Tendonitis
- ☐ spasms /cramps /restless muscles
- ☐ Numbness in the extremities
- ☐ Pain in neck and/or shoulders
- ☐ Weakness
- ☐ Osteoporosis
- ☐ Back pain
- ☐ Athletic injury
- ☐ Tingling/burning in hands or feet
- ☐ Tightness in shoulder muscles
- ☐ Swollen knees/elbows
- ☐ Unable to sit straight
- ☐ Bursitis

PAIN

Please mark any areas of discomfort in the pictures below



How long have you had this pain? _____
Quality of pain (eg. Sharp, stabbing, burning achy, dull ect.) _____
Is this pain constant or does it come and go? _____
How frequently do you have pain _____

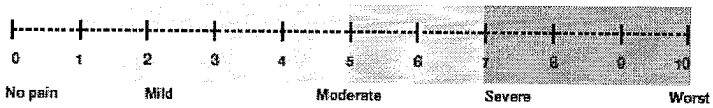
Is your pain better or worse with....(**B** for better/ **W** for worse):

___ Movement ___ Rest
___ Heat ___ Cold
___ Pressure/Massage ___ Morning
___ Afternoon ___ Evening

Rate your pain 0-10

FIGURE 1

Numeric Rating Scale



No pain — Mild — Moderate — Severe — Worst possible pain

The Numeric Rating Scale is used by the patient to indicate severity of pain. Generally patients who score between 1 and 4 on this scale are experiencing mild pain. Scores of 5 and 6 are indicative of moderate pain, while those who score between 7 and 10 are experiencing severe pain.

Source: Von Korff M, Ormel J, Keefe FJ, et al. Grading the severity of chronic pain. Pain. 1992;50:133-139.

FOR OFFICE USE ONLY

Patient Name _____ Date _____

Vital Signs

Physician Signature: _____ Date: _____

- ❑ Dictated Timothy Visser, ND
- ❑ **NOT** dictated