

Living Natural Inc.  
Family Medicine and Natural Healthcare  
Margrit MiKulis, ND  
Erica Waters, ND

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (h): \_\_\_\_\_ (w): \_\_\_\_\_ (c): \_\_\_\_\_

Occupation: \_\_\_\_\_ How long: \_\_\_\_\_

Marital/Relationship status: \_\_\_\_\_

# of Children/Dependents: \_\_\_\_\_

Name of Emergency contact: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Phone: \_\_\_\_\_ Or: \_\_\_\_\_

How did you first hear about Naturopathic Medicine/Living Natural Inc.? \_\_\_\_\_  
\_\_\_\_\_

Please list your chief health concerns and/or symptoms

How long?

1.) \_\_\_\_\_

2.) \_\_\_\_\_

3.) \_\_\_\_\_

4.) \_\_\_\_\_

5.) \_\_\_\_\_

What would you most like to accomplish on your initial visit? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list any pharmaceutical drugs, over the counter medications, vitamins, herbs, or other supplements you are currently taking. Please bring them with you to your initial visit.

1.) _____	<u>Dosage</u>	6.) _____	<u>Dosage</u>
2.) _____		7.) _____	
3.) _____		8.) _____	
4.) _____		9.) _____	
5.) _____		10.) _____	

Have you had any of the following in the last five years?

<b>Test</b>	<b>When</b>	<b>For What reason</b>	<b>Results/Outcome</b>
Bone density	_____	_____	_____
CT Scan	_____	_____	_____
Colonoscopy	_____	_____	_____
EEG	_____	_____	_____
Endoscopy	_____	_____	_____
MRI	_____	_____	_____
Ultra Sound	_____	_____	_____
X-Ray	_____	_____	_____

What hospitalizations have you had? \_\_\_\_\_

\_\_\_\_\_

Please list any known food, drug, or inhalant allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you take or use any of the following?

*Y = presently use      N = never have used      P = have used in the past*

Appetite Suppressants	Y	N	P	Pain Relievers	Y	N	P	Cortisone	Y	N	P
Thyroid Medication	Y	N	P	Sleeping Pills	Y	N	P	Antacids	Y	N	P
Antidepressants	Y	N	P	Tranquilizers	Y	N	P	Laxatives	Y	N	P

**Family History**

<b>Age</b>	<i>If living</i> <b>Health</b>	<b>Age</b>	<i>If deceased</i> <b>Cause of death</b>
------------	-----------------------------------	------------	---

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Siblings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has a blood relative ever had any of the following?

Which relative?

Cancer	Y N	_____
Tuberculosis	Y N	_____
Diabetes	Y N	_____
Heart Disease	Y N	_____
High Blood Pressure	Y N	_____
Asthma/Hay fever	Y N	_____
Kidney Disease	Y N	_____
Mental Illness	Y N	_____
Suicide	Y N	_____
Osteoporosis	Y N	_____
Thyroid Disease	Y N	_____

Review of Personal history:

Y= presently have      N= have never had      P= have had in the past 10 years

**Skin**

Rashes	Y	N	P
Eczema/Hives	Y	N	P
Acne/Boils	Y	N	P
Color Changes	Y	N	P
Itching	Y	N	P
Lumps	Y	N	P
Night Sweats	Y	N	P

**Nose and Sinuses**

Frequent Colds	Y	N	P
Nose Bleeds	Y	N	P
Stuffiness	Y	N	P
Hay Fever	Y	N	P
Sinus Problems	Y	N	P

**Neck**

Lumps	Y	N	P
Swollen Glands	Y	N	P
Goiter	Y	N	P
Pain/Stiffness	Y	N	P

**Respiratory**

Cough	Y	N	P
Sputum	Y	N	P
Spitting up blood	Y	N	P
Bronchitis	Y	N	P
Pleurisy	Y	N	P
Emphysema	Y	N	P
Wheezing	Y	N	P
Asthma	Y	N	P
Shortness of Breath	Y	N	P
At night	Y	N	P
Lying down	Y	N	P
On exertion	Y	N	P
Difficult breathing	Y	N	P
Pain on breathing	Y	N	P
Tuberculosis	Y	N	P
Pneumonia	Y	N	P

**Head**

Headaches	Y	N	P
Migraines	Y	N	P
Head Injury	Y	N	P

**Ears**

Impaired Hearing	Y	N	P
ringing	Y	N	P

Earache	Y	N	P
Dizziness	Y	N	P

**Eyes**

Glasses or contacts	Y	N	P
Eye Pain	Y	N	P
Tearing or dryness	Y	N	P
Glaucoma	Y	N	P
Cataracts	Y	N	P

**Mouth and Throat**

Frequent Sore Throat	Y	N	P
Sore Tongue	Y	N	P
Gum problems	Y	N	P
Teeth Problems	Y	N	P

**Gastrointestinal**

Nausea	Y	N	P
Vomiting	Y	N	P
How many bowel movements Per day			
Is this a change	Y	N	P
Blood in stool	Y	N	P
Gallbladder disease	Y	N	P
Liver disease	Y	N	P
Jaundice	Y	N	P
Change in thirst	Y	N	P
Trouble swallowing	Y	N	P
Belching/gas	Y	N	P
Ulcer	Y	N	P
Hemorrhoids	Y	N	P
Bloating	Y	N	P

**Cardiovascular**

Heart Disease	Y	N	P
Chest Pain	Y	N	P
Angina	Y	N	P
Palpitations	Y	N	P

Fluttering	Y	N	P
High Blood Pressure	Y	N	P
Murmurs	Y	N	P
Swelling in ankles	Y	N	P

**Blood**

Anemia	Y	N	P
Easy bleeding	Y	N	P
Easy bruising	Y	N	P

**Neurological**

Fainting	Y	N	P
Seizures	Y	N	P
Paralysis	Y	N	P
Muscle weakness	Y	N	P
Numbness/tingling	Y	N	P
Loss of memory	Y	N	P

**Female Reproductive**

Age at onset of period			
Length of monthly cycle			
Are cycles regular	Y	N	P
Painful menses	Y	N	P
Excessive flow	Y	N	P
PMS	Y	N	P
Birth Control	Y	N	P
What type			
Number of pregnancies			
Number of live births			
Number of miscarriages			
Difficulty of conceiving	Y	N	P
Sexual Difficulties	Y	N	P
Venereal Disease	Y	N	P

**Urinary**

Pain on urination	Y	N	P
Increased frequency	Y	N	P
Frequency at night	Y	N	P
Inability to hold	Y	N	P
Frequent infections	Y	N	P
Kidney stones	Y	N	P
Kidney Disease	Y	N	P

**Peripheral Vascular**

Deep leg pain	Y	N	P
Cold Hands/feet	Y	N	P
Varicose veins	Y	N	P

**Mental/Emotional**

Depression	Y	N	P
------------	---	---	---

Mood Swings	Y	N	P
Anxiety/nervousness	Y	N	P
Panic attacks	Y	N	P
Tension	Y	N	P
Sense of doom	Y	N	P

**Hair**

Thinning	Y	N	P
Falling out	Y	N	P
Balding/Alopecia	Y	N	P
Hirsutism	Y	N	P
Scalp problems	Y	N	P

**Male Reproductive**

Hernias	Y	N	P
Testicular masses	Y	N	P
Testicular pain	Y	N	P
Sexual difficulties	Y	N	P
Prostate disease	Y	N	P
Venereal disease	Y	N	P
Discharge or sores	Y	N	P
Erectile dysfunction	Y	N	P

**Daily Habits**

Exercise	Y	N	P
What form			
How often			
Use recreational drugs	Y	N	P
Use tobacco	Y	N	P
Use alcohol	Y	N	P
Sleep well	Y	N	P

Awake rested?                      Y N P  
Average 7 hours?                    Y N P

**Please give an example of a typical days**

**Worth of food:**

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Beverages \_\_\_\_\_

Snacks \_\_\_\_\_