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.

	Dosage		Dosage
1.)		6.)	
2.)		7.)	
3.)		8.)	
4.)		9.)	
5.)		10.)	

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

Test	When	For What reason	Results/Outcome
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

	If living		*If deceased*	
	Age	**Health**	**Age**	**Cause of death**
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