Green Mountain Medicine
102 S Euclid Ave, Suite 110, Sandpoint, Idaho 83864
www.greenmtmed.com • 208-255-1951

Patient Health History

Name: _____ Today's Date: _____

Parent's Name (if patient is a child): _____

Age: _____ Birth Date: _____ Gender: M F **Marital Status: _____**

Live with: ____ spouse ____ parents ____ relatives ____ friends ____ alone ____ other
Do you have children? Y N **If yes, please include name, age and sex of each child:**

_____

_____

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ E-mail: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about Green Mountain Medicine? _____

1. **Are you currently receiving health care?** Y N From whom: _____
   When and where did you last receive health care, and for what reason? _____
   _____

2. **Please identify the health concerns that brought you to the clinic today (in order of significance):**
   Condition Past Treatment

   _____

   _____

   _____

3. **When did your health complaints begin and what do you think caused them?**

   _____

   _____

   _____

4. **General State of Health (circle one): Good Fair Poor Comments: _____**

   _____

5. **Do you have any expectations of your <u>first visit</u> to Green Mountain Medicine? (Please list)**

   _____

6. **Do you have any <u>long-term</u> expectations of working with Green Mountain Medicine? (Please list)**

   _____

7. **Do you have any expectations of me personally as your natural health care provider? (Please list)**

   _____

8. **What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)**

_____

9. **What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)**

_____

10. **What is your present level of commitment to address any underlying cause of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed.)**

0% 0 1 2 3 4 5 6 7 8 9 10 100%

11. **Height: _____ Weight: _____ Max Weight: _____ When: _____**

Mark the condition you have had:

12. **Childhood Illness**:
___Scarlet Fever ___Diphtheria ___Rheumatic Fever ___Mumps ___Measles ___Chicken Pox

Other: (please specify) _____

13. **Immunizations**:
___Polio ___Tetanus ___Measles/Mumps/Rubella ___Pertussis ___Diphtheria ___Hepatitis B

Other: (please specify) _____

14. **Do you have any infectious, contagious, or other chronic or recent illness(es) not described above?**

If yes, please explain: _____

15. **Severe illnesses, injuries, surgeries or hospitalizations (include reason and date):**

_____

_____

16. **Please list all allergens, foods, drugs, and medications you are hypersensitive or allergic to and the type of reaction:** _____

_____

17. **Please list all prescription medications you are currently taking (include dosage):**

_____

_____

18. **Please list all over-the-counter medications, vitamins, and supplements that you are currently taking (include dosage):**

_____

_____

19. **X-Rays/CAT Scans/MRI's/Special studies**:

Reason	When	Reason	When
_____		_____	
_____		_____	

20. **Family History:**

	Mother	Father	Siblings	Spouse	Children
Deceased (Y/N)	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____
Age	_____	_____	_____	_____	_____

Patient Name:_____ Date:_____

Family History (cont.):	Mother	Father	Siblings	Spouse	Children
Health (G=good, P=Poor)	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____

For the following, please mark "C" for current experiences and "P" for past experiences:

Emotional
__ Mood Swings __ Nervousness __ Mental Tension __Depression

Other: (please specify) _____

Energy and Immunity
__Fatigue/Chronic Fatigue Syndrome __ Slow Wound Healing __Chronic Infections

Head, Eye, Ear, Nose, Throat
__Impaired Vision __Eye Pain/Strain __Glaucoma __Glasses/Contacts __Tearing/Dryness __Impaired Hearing

__Ear Ringing __Earaches __Headaches __Sinus Problems __Nose Bleeds __Teeth Grinding

__Frequent Sore Throat __TMJ/Jaw Problems __Hay Fever or Allergies

Respiratory
__Pneumonia __Frequent Common Colds __Difficulty Breathing __Emphysema __Persistent Cough __Pleurisy

__Asthma __Tuberculosis __Shortness of Breath Other:_____

Cardiovascular
__Heart Disease __Chest Pain __ Swelling of ankles __High Blood Pressure __ Palpitations __Stroke

__Heart Murmurs __Rheumatic Fever __Varicose Veins

Gastrointestinal
__Ulcers __Changes in Appetite __ Nausea/Vomiting __ Abdominal Pain __Heartburn __Belching

__Gas/Bloating __Liver Disease __Hepatitis B or C __Hemorrhoids

Stool
__Diarrhea __Constipation __ Undigested Food in Stool __Mucous or Blood in Stool

Genito-Urinary Tract
__Kidney Disease __ Painful Urination __Frequent Urinary Tract Infections __Frequent Urination

__Kidney Stones __ Impaired Urination __Urination at night __Blood in Urine

__Sexually Transmitted Disease(s): (please specify) _____

Female Reproduction
__Irregular Cycles __Breast Lumps/Tenderness __Nipple Discharge __Heavy Flow __Light Flow __Clotting

__Bleeding Between Cycles __Vaginal Discharge __Premenstrual Problems __Menopausal Symptoms __

__ Post Menopause __Difficulty Conceiving __Pain with Intercourse

Menstrual/Birthing History
Age of First Menses: _____ #of Days of Menses: _____ Length of Cycle: _____
Birth Control Now: _____ Birth Control Use in the Past: _____
# of Pregnancies: _____ # of Miscarriages: _____ # of Abortions: _____ # of Live Births: ____
Are You Fertile? Y N Age at Menopause _____
Do you have any reason to believe you might be pregnant**?** Y N

Male Reproductive
__Sexual Difficulties __Prostate Problems __Testicular Pain/Swelling __Penile Discharge
__Pain with Intercourse __Fertility Problems

Musculoskeletal
__Neck/Shoulder Pain __Muscle Spasms/Cramps __Arm Pain __Upper Back Pain __Mid Back Pain
__Low Back Pain __Leg Pain __Joint Pain Other: _____

Neurologic
__Vertigo/Dizziness __Paralysis __Numbness/Tingling __Loss of Balance __Seizures/Epilepsy

Endocrine
__*Hypo*thyroid __*Hyper*thyroid __*Hypo*glycemia __Diabetes Mellitus __Night Sweats __Feeling Hot or Cold
__Hot Flashes

Other
__Anemia __Cancer (please specify type): _____ __Rashes __Eczema/Hives __Cold Hands/Feet

21. **Lifestyle**

A. **Typical Food Intake**

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

B. **Typical Liquid Intake**

Water intake per day: _____

Other fluid intake per day (please specify type and amount of each): _____

_____

C. **When do you go to sleep?** _____ **When do you wake?** _____

D. **Occupation:** _____ Employer: _____

Hours/week: _____

Do you enjoy work? Y N Why/Not? _____

E. **Have you experienced any major traumas or unsettling life experiences (mental, emotional, spiritual, physical) that did, or still affects you deeply?** Y N

Comments: _____

_____

F. **Nicotine/Alcohol/Caffeine/Recreational drug use:** _____

How Often? _____

G. **Exercise:** _____

H. **Hobbies:** _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM. This information will be used to guide a thorough evaluation of your health condition and create a health and wellness plan that is personalized to your needs.