

Queen Anne Naturopathic Center, Ltd.

315 1st Avenue West, #A, Seattle, WA 98119 (206) 281-4282 FAX 285-6854

CONFIDENTIAL ADULT PATIENT PROFILE

(This is a confidential medical record and will not be released without your authorization)

Please print clearly!

NAME _____ Sex _____ Today's date _____

ADDRESS _____

CITY/STATE/ZIP _____ AGE _____

BIRTH DATE _____ SS# _____ - _____ - _____

PHONE home: (____) _____ - _____ work: (____) _____ - _____ Cell: (____) _____ - _____

E-mail: _____

In Case of Emergency, Contact: _____ Relationship _____

PHONE home: (____) _____ - _____ work: (____) _____ - _____ Cell: (____) _____ - _____

Please tell us how you found out about our office or who you were referred by: _____

Are you currently being seen by other health practitioners? (Please list names & phone # if avail.)

Social History:

Your Occupation _____ Employer _____

Check: Current Spouse/Partner Single Separated Divorced Widowed

Children? (if yes, list sex and ages) _____

Educ.Level: HS not completed HS/GRD College not completed College Grad.

Spiritual practice? Yes No Relaxation/Amusements/Hobbies: _____

Physical Complaints: Blood Type: _____

What is the reason for your visit? Please list your most important present health concerns in order of significance.

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

List prescription (Rx) and non-prescription (O-T-C) medications presently taking, with dosage:

List Vitamins, minerals, herbs, homeopathic remedies presently taking, with dosage:

Past Hospitalizations, Surgeries: (List reason, type and your approximate age or year it occurred)

Other past injuries, accidents, serious illnesses or childhood illnesses?

PLEASE COMPLETE INFORMATION ON REVERSE

Last complete physical: (month & yr.) _____ Reason _____
 Men age 35+ and Women age 45+: Last Cholesterol Lab test? (month & yr.) _____
 Women - Last PAP smear: (month & yr.) _____ Results? _____ normal _____ abnormal
 Last mammogram: (month & yr.) _____ Results? _____ normal _____ abnormal
 Men - Last PSA blood test: (month & yr.) _____ Results? _____ normal _____ abnormal
 Last prostate exam: (month & yr.) _____ Results? _____ normal _____ abnormal

Are you allergic to any medications or supplements? _____ **YES** _____ **NO**
 If YES, list drug/supplement and reaction: _____

Are you allergic to any foods? Are there any foods that don't agree with you? (list food and reaction)

Any environmental allergies? _____

Lifestyle History:

Average hours of sleep/night _____ Do you feel this is enough sleep? _____
 Describe your sleep: _____ unbroken I wake up _____ time(s)/night Rested in AM? _____
 Describe any other difficulties or patterns with your sleep _____

How many hours do you work per week on average: _____
 Rate your stress level (5 being most stressful) 1 2 3 4 5
 Rate your energy level (5 being most energetic) 1 2 3 4 5
 Rate your activity level: a. sedentary b. slightly active c. moderately active d. significantly active
 Exercise periods per week? _____ Duration of exercise periods _____
 Exercise activities: _____
 Freq. of bowel movements: _____ per day or _____ per week, ___ loose ___ normal ___ hard
 Cigarette/Cigar/Chewing tobacco use history: _____ never
 _____ former: (between ages _____ - _____ packs/day _____) ___ current: (since age _____ packs/day _____)
 Alcohol intake history/qty per day or week: _____
 Coffee/Soda/Caffeine intake history/qty per day: _____
 Recreational drug use history: _____

Diet History:

Dietary preference: ___ Std. American ___ Reduced red meat ___ Chicken/Turkey/Fish
 ___ Fish & Vegetarian ___ Vegetarian only (How many years? _____) ___ Whole grains
 I eat on average _____ meals per day _____ snacks per day _____ I graze all day

FAMILY HEALTH HISTORY - CAUSE OF DEATH: (blood relatives)

still alive at age: OR age at death: Cause of death:

MOTHER: _____
 Maternal GM: _____
 Maternal GF: _____
 FATHER: _____
 Paternal GM: _____
 Paternal GF: _____
 Longevity present in other family members? _____

My appetite is:

I eat on average # servings per day (/d) or week (/w):
 _____ meat _____ salads _____ vegetables _____ fruit
 _____ whole grains _____ bread/white rice/potato

How much do you drink daily? (qty - i.e. ounces, glasses, cups/type - i.e. soda, tea, coffee, water)
