NATURE'S PATH OF INTEGRATED HEALTH

Kim D. Furtado, N.D.
1307 Savannah Road
Lewes, DE 19958
302-945-2107

Date: _____

Patient Profile

Name:_____ Age:_____ Birthdate: _____ Gender: M F

Address:_____

Phone: **hm**_____Can messages be left for you here? Y N **wk**_____Can messages be left here? Y N

Occupation: _____ Employer: _____

email: _____

Name of Emergency Contact: _____ Phone: _____

Primary Care Physician: _____Phone:_____

Who can I thank for referring you to me? _____

A note to patients: Please take the time to carefully complete this health history questionnaire. Naturopathic medicine involves providing the physician a complete picture of the patient physically, mentally & emotionally. This is a confidential record of your medical history and will not be released except when you have authorized me to do so. Thank you.

Present Health Concerns: Please list your most important health concerns in their order of significance.

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

What goals do you have for your visit at the clinic today?

Primary Goal: _____

Other Goals: _____

Have you ever consulted a naturopathic doctor before? Yes No

Do you have any questions about naturopathic medicine or Nature's Path of Integrated Health before we get started?_____

Prior Doctor-Patient Relationship

Please take a moment to reflect on your past relationships with physicians and note how the relationship with future physicians could improve to optimize your health care. What do you need from a physician in relation to achieving your goals and goals of wellness (creativity, energy, enjoyment, health, balance, etc)? How can you become more effective in your role with your physician?

_____

_____

_____

PLEASE TURN OVER →

Please list the medications that you are currently taking, with dosages:
1.) _____ 4.) _____
2.) _____ 5.) _____
3.) _____ 6.) _____
Please list any vitamins, minerals, herbs or homeopathic remedies that you are presently taking:
1.) _____ 5.) _____
2.) _____ 6.) _____
3.) _____ 7.) _____
4.) _____ 8.) _____
Please list any allergies that you have to any of the following:
Drugs: _____ Foods:_____
Environmental Sources: (ex. Pollen, grasses, etc…) _____
What happens when you have an allergy attack?_____

Personal Habits:

Tobacco: _____ packs per day; smokeless tobacco, cigars
Coffee/black tea/ cola _____ cups per day/week/month
Alcohol _____ drinks per day/week/month
Recreational drugs _____

Do you follow any particular diet regimens or restrictions? YES NO
If yes, please describe: _____
Do you exercise regularly? YES NO If yes, please describe:
_____
Do you make time for rest, relaxation, or meditation during the day and/or before bed? YES NO
Have you ever been expose to toxic chemical, solvents or other possible toxins? YES NO
If yes, please describe: _____

Past History:

Hospitalizations: (Please list reason and dates)
_____
_____
Serious Illnesses and Injuries:
_____
_____
Date of last complete physical exam: _____

Social History:

Please circle those that apply: single married significant other
Do you have children? YES NO How many?_____ Ages:_____
Does income meet monthly expenses? YES NO
Have you traveled outside the US in the past year? YES NO Where?_____
Please describe briefly your religious and/or spiritual background/beliefs_____
_____

Family History: Please fill in the boxes below for each condition that applies to one of you family members.

	YES	WHO	Comments		YES	WHO	Comments
Alcoholism				Hay Fever, Hives			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Diabetes				Stroke			
Eczema				Tuberculosis			
Epilepsy				Other:			

PATIENT PROFILE

REVIEW OF SYSTEMS: **Y =** a condition you have now. **N** = never had **P =** have had in the past
For the following, PLEASE CIRCLE, or fill in blanks.

GENERAL
- Weight _____
- Weight 1 year ago _____
- Maximum weight _____
- When _____
- Height _____
- Night Sweats Y P N
- Fatigue Y P N

SKIN
- Rashes Y P N
- Inflammation Y P N
- Infection Y P N
- Growths Y P N
- Changes in hair/nails Y P N

HEAD
- Headache Y P N
- Head Injury Y P N

EYES
- Impaired vision Y P N
- Eye pain Y P N
- Tearing or dryness Y P N
- Double vision Y P N

EARS
- Impaired hearing Y P N
- Ringing Y P N
- Ear ache/itch Y P N
- Dizziness Y P N

NOSE & SINUSES
- Frequent colds Y P N
- Nose bleeds Y P N
- Stuffiness Y P N
- Sinus problems Y P N
- Post nasal drip Y P N

MOUTH & THROAT
- Frequent sore throat Y P N
- Sore tongue Y P N
- Sores in mouth /on lips Y P N
- Gum problems Y P N
- Hoarseness Y P N
- Dental Problems Y P N

NECK
- Swollen glands Y P N
- Pain or stiffness Y P N

BLOOD
- Anemia Y P N
- Easy bleeding or bruising Y P N

RESPIRATORY
- Cough Y P N
- Spitting up blood Y P N
- Wheezing Y P N
- Difficulty breathing Y P N
- Pain on breathing Y P N
- Shortness of breath Y P N
- " lying down Y P N
- " at night Y P N
- Positive TB test ever? Y P N

HEART
- Heart disease Y P N
- High blood pressure Y P N
- Rheumatic fever Y P N
- Chest pain Y P N
- Swelling in ankles Y P N
- Palpitations, fluttering Y P N

DIGESTION
- Trouble swallowing Y P N
- Heartburn Y P N
- Stomach pain Y P N
- Change in thirst Y P N
- Change in appetite Y P N
- Nausea Y P N
- Vomiting Y P N
- Bowels move: daily more less
- Loose stools Y P N
- Is this a change? Y N
- Blood in stools Y P N
- Belching or gas Y P N
- Liver/gall bladder disease Y P N
- Hemorrhoids Y P N

CIRCULATION
- Deep leg pain Y P N
- Cold hands/ feet Y P N
- Varicose veins Y P N

MALE REPRODUCTION

Hernias	Y	P	N
Testicular masses	Y	P	N
Testicular pain	Y	P	N
Discharge or sores	Y	P	N
Difficulty stopping or starting urination	Y	P	N
Ever any prostate problems	Y	P	N

Date of last prostate exam _____

FEMALE REPRODUCTION

Age menses began	_____		
No. of days menstrual flow	_____		
Length of complete cycle	_____		
DATE of last menstrual period	_____		
Bleeding between periods	Y	P	N
Are cycles regular	Y	P	N
Cramps	Y	P	N
Abnormal vaginal discharge	Y	P	N
Excessive flow	Y	P	N
PMS	Y	P	N
DATE of LAST PAP Smear	_____		
Results were: normal abnormal don't know			
EVER had an abnormal PAP?	Y	P	N
No. of pregnancies	_____		
No. of live births	_____		
No. of miscarriages	_____		
No. of abortions	_____		
Menopausal symptoms	Y	P	N

GENERAL REPRODUCTION (males and females)

Birth control?	Y	P	N
What type?	_____		
(F)Ever used birth control pills?	Y	P	N
If so, how long?	_____		
Difficulty conceiving	Y	P	N
Are you sexually active?	Y	P	N
Sexual difficulties	Y	P	N
Pain during intercourse	Y	P	N
Venereal disease	Y	P	N

(The following question is optional)

Sexual orientation:

Heterosexual __ Homosexual __ Bisexual___

BREASTS

Do you self exam regularly	Y	P	N
Lumps	Y	P	N
Pain or tenderness	Y	P	N
Nipple Discharge	Y	P	N

MENTAL / EMOTIONAL

Depression	Y	P	N
Mood Swings	Y	P	N
Anxiety or nervousness	Y	P	N
Tension	Y	P	N
Suicide thoughts	Y	P	N
Suicide attempts	Y	P	N

ENDOCRINE

Ever had any thyroid problem	Y	P	N
Heat or cold intolerance	Y	P	N
Hypoglycemia	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Easy weight gain	Y	P	N

NEUROLOGIC

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

URINARY

Pain on urination	Y	P	N
Increase frequency	Y	P	N
Frequency at night	Y	P	N
Inability to hold urine	Y	P	N
Bladder infections	Y	P	N

MUSCULOSKELETAL

Joint pain or stiffness	Y	P	N
Broken bones	Y	P	N
Muscle spasms or cramps	Y	P	N
Weakness	Y	P	N

INDICATE on diagram any PROBLEM AREAS:

IS THERE ANY OTHER PROBLEM YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR?_____