

# CHAMPLAIN CENTER FOR NATURAL MEDICINE

## Adult Patient Profile

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

### Present Health Concerns

Please list your health concerns in order of priority, including date of onset and severity of symptoms.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

What do you believe is causing your most important health concerns? \_\_\_\_\_

What goals do you have for your visit today? \_\_\_\_\_

**Healthcare Practitioners:** Please list your current medical practitioners with their contact information.

	Practitioner's Name	Office Name	City	Phone
Primary Care				
OB/Gyn				
Specialist				
Therapist				
Other				
Pharmacy				

**Medications:** Please list any prescription drugs, over-the-counter medications and supplements (vitamins, minerals, nutrients, herbs, homeopathic remedies, etc.) you are currently taking.

Medication/Supplement	Reason	Date began	Dose

**Allergies:** Please list and describe any severe or life-threatening allergies (medications, stings, foods, etc.):

(OVER)

**Review of Systems:** Check  symptoms that you currently experience.

Constitutional	Heart & Circulation	Digestion & Intestine	WOMEN: Reproductive
Max weight: ____ Year: ____	<input type="radio"/> Heart murmur	<input type="radio"/> Bad breath	Age period started: ____ yrs
Min weight: ____ Year: ____	<input type="radio"/> Irregular heartbeat	<input type="radio"/> Excessive thirst	Length of cycle: ____ days
<input type="radio"/> Appetite change	<input type="radio"/> Chest pain	<input type="radio"/> Difficulty swallowing	Length of flow: ____ days
<input type="radio"/> Weight change	<input type="radio"/> Heart palpitations	<input type="radio"/> Indigestion	Last menstrual period: ____
<input type="radio"/> Fevers <i>or</i> Chills	<input type="radio"/> Lightheaded	<input type="radio"/> Belching	# Pregnancies: ____
<input type="radio"/> Sweats	<input type="radio"/> Fainting	<input type="radio"/> Heartburn / Reflux	# Live births: ____
<input type="radio"/> Feel hot <i>or</i> cold	<input type="radio"/> Blood clots	<input type="radio"/> Nausea	# Miscarriages: ____
<input type="radio"/> Fatigue	<input type="radio"/> Deep leg pain on walking	<input type="radio"/> Vomiting	# Abortions: ____
<input type="radio"/> Weakness	<input type="radio"/> Varicose veins	<input type="radio"/> Abdominal pain <i>or</i> cramping	Last pap smear: ____
<b>Eyes</b>	<input type="radio"/> Swelling of feet / ankles	<input type="radio"/> Gas or Bloating	Last mammogram: ____
<input type="radio"/> Eye pain	<input type="radio"/> Cold hands / feet	# Bowel movements/ day: ____	Last DEXA scan: ____
<input type="radio"/> Poor night vision	<input type="radio"/> Anemia	<input type="radio"/> Constipation	<input type="radio"/> Irregular menstrual cycle
<input type="radio"/> Glasses <i>or</i> Contacts	<input type="radio"/> Easy bruising	<input type="radio"/> Loose stools <i>or</i> Diarrhea	<input type="radio"/> Bleeding between periods
Near <i>or</i> Far sighted	<input type="radio"/> Bleeding tendency	<input type="radio"/> Mucus in stool	<input type="radio"/> Heavy periods
<input type="radio"/> Blurred <i>or</i> Double vision	<input type="radio"/> Blood transfusions	<input type="radio"/> Blood in stool	<input type="radio"/> Painful periods
<input type="radio"/> Cataracts	<b>Chest &amp; Lungs</b>	<input type="radio"/> Rectal pain/itching	<input type="radio"/> Premenstrual syndrome
<input type="radio"/> Dry eyes	<input type="radio"/> Shortness of breath	<input type="radio"/> Hemorrhoids	<input type="radio"/> Pelvic pain
<b>Ears, Nose, Mouth, Throat</b>	At rest Walking Lying down	<input type="radio"/> Hernia	<input type="radio"/> Abnormal pap smear
<input type="radio"/> Ringing in ears	<input type="radio"/> Wheezing <i>or</i> asthma	<input type="radio"/> Jaundice	<input type="radio"/> Vaginal discharge
<input type="radio"/> Earaches	<input type="radio"/> Cough: wet <i>or</i> dry	<b>Muscles, Bones &amp; Joints</b>	<input type="radio"/> Vaginal itching or soreness
<input type="radio"/> Itchy ears	<input type="radio"/> Breast lump <i>or</i> pain	<input type="radio"/> Neck pain	<input type="radio"/> Sores on genitals
<input type="radio"/> Excessive ear wax	<input type="radio"/> Nipple discharge	<input type="radio"/> Back pain	<input type="radio"/> Infertility
<input type="radio"/> Hearing loss <i>or</i> hearing aid	<input type="radio"/> Self breast exams	<input type="radio"/> Muscle pain	<input type="radio"/> Sexual difficulties
<input type="radio"/> Nosebleeds	<b>Neurological</b>	<input type="radio"/> Joint Pain: <i>indicate R or L</i>	<input type="radio"/> Pain with intercourse
<input type="radio"/> Stuffy <i>or</i> Runny nose	<input type="radio"/> Dizziness	<input type="radio"/> wrist <input type="radio"/> fingers	<input type="radio"/> Menopausal symptoms
<input type="radio"/> Postnasal drip	<input type="radio"/> Poor balance	<input type="radio"/> elbow <input type="radio"/> shoulder	<input type="radio"/> Hormone Replacement
<input type="radio"/> Sinus problems	<input type="radio"/> Poor coordination	<input type="radio"/> hip <input type="radio"/> knee	<b>MEN: Reproductive</b>
<input type="radio"/> Change in taste <i>or</i> smell	<input type="radio"/> Tremors <i>or</i> shaking	<input type="radio"/> ankle <input type="radio"/> foot	<input type="radio"/> Sores on genitals
<input type="radio"/> Teeth / Gum problems	<input type="radio"/> Seizures	<input type="radio"/> Joint swelling	<input type="radio"/> Discharge
<input type="radio"/> Grinding teeth	<input type="radio"/> Headaches	<input type="radio"/> Morning stiffness: ____ hours	<input type="radio"/> Testicle lump/swelling/pain
<input type="radio"/> Dentures	<input type="radio"/> Migraines	<input type="radio"/> Joint replacements	<input type="radio"/> Prostate problems
<input type="radio"/> Mouth sores	<input type="radio"/> Numbness <i>or</i> tingling	<input type="radio"/> Muscle weakness	<input type="radio"/> Infertility
<input type="radio"/> Dry mouth	<input type="radio"/> Nerve pain	<input type="radio"/> Muscle cramps	<input type="radio"/> Sexual difficulties
<input type="radio"/> Sore throat	<input type="radio"/> Memory loss	<b>Skin, Hair, Nails</b>	<input type="radio"/> Self testicular exam
<input type="radio"/> Hoarseness	<input type="radio"/> Poor concentration	<input type="radio"/> Acne	<b>Bladder &amp; Kidney</b>
<input type="radio"/> Jaw clicking <i>or</i> pain	<input type="radio"/> Changes in speech	<input type="radio"/> Rashes	<input type="radio"/> Waking to urinate
<input type="radio"/> Facial pain	<b>Mental / Emotional</b>	<input type="radio"/> Itching <i>or</i> hives	<input type="radio"/> Loss of bladder control
<b>Immune System</b>	<input type="radio"/> Mood swings	<input type="radio"/> Dry skin <i>or</i> eczema	<input type="radio"/> Frequent / Urgent urination
<input type="radio"/> Frequent infections	<input type="radio"/> Anger, frustration, irritability	<input type="radio"/> Moles <i>or</i> growths	<input type="radio"/> Interrupted flow
<input type="radio"/> Allergies to food	<input type="radio"/> Sadness <i>or</i> anxiety	<input type="radio"/> Poor wound healing	<input type="radio"/> Recurrent infections
<input type="radio"/> Allergies to environment	<input type="radio"/> Phobias	<input type="radio"/> Hair loss	<input type="radio"/> Painful urination
<input type="radio"/> Lymph gland swelling / pain	<input type="radio"/> Insomnia <i>or</i> disrupted sleep	<input type="radio"/> Nail problems	<input type="radio"/> Blood or pus in urine
<input type="radio"/> Other:		<input type="radio"/> Other:	<input type="radio"/> Kidney stones

**Past Medical History:** Please list the date of or age at each event and describe:

Serious Illnesses and Injuries: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Date of last physical/annual exam: \_\_\_\_\_ Date of last blood tests: \_\_\_\_\_

**Childhood Illnesses:** Please check all that apply. Your health as a child was:  Good  Fair  Poor

- |  |  |  |
|--|--|--|
| <input type="radio"/> Chicken Pox              | <input type="radio"/> Mononucleosis (Mono)       | <input type="radio"/> Rheumatic Fever          |
| <input type="radio"/> Diphtheria               | <input type="radio"/> Mumps                      | <input type="radio"/> Tonsillitis              |
| <input type="radio"/> Ear Infections           | <input type="radio"/> Pertussis (whooping cough) | <input type="radio"/> Scarlet Fever            |
| <input type="radio"/> German Measles (Rubella) | <input type="radio"/> Pneumonia                  | <input type="radio"/> Strep Throat (recurrent) |
| <input type="radio"/> Measles                  | <input type="radio"/> Polio                      |  |

**Personal and Family Medical History:**

Please check the  box next to each condition that applies to you or one of your biological family members.

	YOU	Mom	Dad	Grandparents				Siblings				
				PGM	PGF	MGM	MGF					
<i>Current Age or Age at Death</i>												
Alcohol / Drug Abuse												
Allergies <i>or</i> Hay Fever												
Alzheimer's <i>or</i> Dementia												
Anemia												
Anxiety / Panic Attacks												
Arthritis / Joint Disease												
Asthma												
Autoimmune Disease												
Bleeding Disorder												
Cancer ( <i>what type?</i> )												
Celiac Disease												
Crohns Dis / Ulcerative Colitis												
COPD / Emphysema												
Depression / Suicide attempt												
Diabetes												
Eczema												
Epilepsy <i>or</i> Seizures												
Glaucoma												
Gall Bladder Disease												
Migraines / Headaches												
Heart Attack												
Heart Disease												
High Blood Pressure												
High Cholesterol												
HIV / AIDS												
Kidney Disease												
Liver Disease / Hepatitis												
Osteoporosis												
Schizophrenia												
Stroke												
Thyroid disorder												
Other:												

