Craig Peterson, ND, LAc, FABNO

INTEGRATIVE ONCOLOGY

PATIENT HEALTH INFORMATION

CURRENT HEALTH HISTORY

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: _____ Nickname: _____ Today's Date: _____

Present Health Concerns:

A note to our patients: Please complete this questionnaire as thoroughly as possible in order to aid your provider. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

1. What are your most important health concerns? List in order of importance and whether you have any diagnosis:
   a) _____
   b) _____
   c) _____
   d) _____
   e) _____

Current Medications:

Name of Medication/supplement	Strength	Dosing Directions
Check box if none ☐		

Do you have any severe or life threatening allergies to medications or anything else? ☐ Yes ☐ No

If YES, please explain: _____

Past History:

Please also list the year the event happened:

Hospitalizations/Surgeries: _____

Serious Illnesses and Injuries: _____

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Family History:

Do you or anyone in your family have a history of any of the following? (please place a "**C**" for current or "**P**" for past)

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Addictions									
Allergies									
Anemia									
Arthritis									
Asthma									
Cancer									
Depression									
Diabetes									
Eczema									
Epilepsy									
Headaches									
Heart Disease									
Hepatitis									
High Blood Pressure									
Kidney Disease									
Stroke									
Tuberculosis									
Other:									

Social History:

Please check those that apply: ☐ Single ☐ Married ☐ Significant other.

Do you have any children? ☐ Yes ☐ No Please list their age(s) _____

Do you have a religious or spiritual practice? ☐ Yes ☐ No If so, what kind? _____

What are your interest and hobbies: _____

What is your occupation or if retired what was your occupation? _____

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For the following, check any of the boxes that applies to you currently:

Energy and Immunity

- ☐ Fatigue
- ☐ Food Allergies
- ☐ Seasonal Allergies
- ☐ Lymph Gland Swelling
- ☐ Anemia
- ☐ Chronic Fatigue Syndrome
- ☐ Thyroid Problems
- ☐ Tendency to Catch Colds
- ☐ Unexplained weight loss

Emotions/Sleep

- ☐ Mood Swings
- ☐ Anxious/Worried
- ☐ Easy to Anger
- ☐ Tearful
- ☐ Unusually Fearful
- ☐ Obsessive in Work, Relationships, etc
- ☐ Suicide Attempts
- ☐ Insomnia
- ☐ Nightmares
- ☐ Difficulty Falling
- ☐ Difficulty Staying Asleep
- ☐ Difficulty Making Decisions

Skin

- ☐ Rashes/Eczema/Hives/Psoriasis
- ☐ Dry hair or hair loss
- ☐ Changes in Skin Color
- ☐ Easy Bruising
- ☐ Acne
- ☐ Dry/Itchy Skin
- ☐ Rosacea

Head, Eye, Ear, Nose & Throat

- ☐ Glasses/Contacts
- ☐ Eye Dryness
- ☐ Blurry Vision
- ☐ Poor Night Vision
- ☐ Ear Ringing
- ☐ Hearing Difficulties
- ☐ Headaches
- ☐ Migraines
- ☐ Teeth Grinding/TMJ
- ☐ Sore Throat
- ☐ Sinus Congestion/ Infections
- ☐ Dry Mouth/Bad Breath
- ☐ Mouth Sores/Bleeding Gums

Respiratory/Cardiovascular

- ☐ Shortness of Breath
- ☐ Asthma/Wheezing
- ☐ Cough
- ☐ Phlegm; Color: _____
- ☐ Pneumonia
- ☐ Chest Pain
- ☐ Palpitations/Fluttering
- ☐ Poor Circulation (Cold hands/feet)
- ☐ Varicose veins
- ☐ Swollen hands/feet
- ☐ Blood clots
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Irregular Heartbeat
- ☐ Hot/Cold Intolerance
- ☐ Increase in Thirst

Musculoskeletal

- ☐ Neck/Shoulder Pain
- ☐ Muscle Spasms/ Cramps/weakness
- ☐ Arm Pain
- ☐ Finger pain/tingling/numbness
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg/Knee Pain
- ☐ Foot Pain
- ☐ Joint Pain or Swelling (Please Describe):

_____

Gastrointestinal

- ☐ Ulcers
- ☐ Food Cravings
- ☐ Changes in Appetite
- ☐ Nausea/Vomiting
- ☐ Bloating/Pain
- ☐ Gas
- ☐ Heartburn/Reflux
- ☐ Belching
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stools
- ☐ Low Blood Sugar
- ☐ Liver Gallbladder disease
- ☐ Pancreatitis

Neurological

- ☐ Vertigo/Dizziness
- ☐ Numbness/Tingling/ Paralysis
- ☐ Loss of Balance
- ☐ Loss of Memory
- ☐ Difficulty Concentrating

Kidney/Urinary

- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urinary Tract Infections
- ☐ Frequent Urination
- ☐ Urination at Night
- ☐ Edema/Swelling
- ☐ Reduced sexual energy

Female Health

- ☐ Irregular cycle
- ☐ Heavy flow (flooding)
- ☐ Light flow (trickling)
- ☐ Clotting of menstrual blood
- ☐ Premenstrual moodiness
- ☐ Breast tenderness
- ☐ Painful Periods (If checked, is the pain before, during and/or after period?

_____

- ☐ Low back pain with periods
- ☐ Hot flashes
- ☐ Vaginal Dryness
- ☐ Nipple discharge
- ☐ Breast Lump/Cysts
- ☐ Uterine fibroids
- ☐ PCOS
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Unusual Vaginal Discharge/Odor
- ☐ Frequent Yeast Infections
- ☐ History of STD

Male Health

- ☐ Prostate Enlargement
- ☐ Prostatitis
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Decreased Libido
- ☐ Groin Pain
- ☐ Low Sperm Count
- ☐ History of STD

provider: _____

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Personal Habits:

Do you use any of these substances regularly:

☐ Tobacco: How long have you smoked? _____ How much do you smoke a day? _____

☐ Coffee/black tea/soda: How many cups of coffee a day? _____ How many sodas a day? _____

☐ Alcohol: ☐ Beer ☐ Wine ☐ Liquor: How often do you drink? _____

☐ Recreational drugs: Describe: _____

Do you eat 3 meals a day? ☐ Yes ☐ No

Please tell me about your typical food intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluids: _____

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

Do you exercise regularly? ☐ Yes ☐ No What type? _____

How long? _____ How often? _____

Reviewed with patient, Provider's signature: _____ Date: _____