

NAME: _____ DOB: _____ DATE _____

HEALTH HISTORY SHEET

Date of Service:

Welcome to Walla Walla Naturopathic, PLLC.! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Last Name:		First:		Age/Date of Birth		Doctor Notes <i>please do not write in this area</i>			
Presenting Problem(s)									
Family Medical History: Adopted /Past or Personal Medical History									
	Yes	No	Self	Other	Year				
Allergies, asthma, hay fever									
Liver Disease									
Alcoholism									
Arthritis									
Bleeding problems									
Gall Bladder Disease									
Cancer									
Emphysema									
Epilepsy or seizures									
Heart Trouble									
Depression/Anxiety/Other									
Headaches									
Rheumatic fever									
Stroke									
Osteoporosis									
Thyroid disease/goiter									
Neurological Disease									
High Blood Pressure									
High Cholesterol									
High or Low Blood Sugar									
Obesity									
Autoimmune Disease									
OTHER <i>Please list</i>									
Major Surgeries:									
Drug Allergies:									
Prescription Medications	Dates		Over the counter Medications	Dates		Vitamins/Herbs/Other Remedies			

NAME: _____ DOB: _____ DATE _____

Determinants of Health: Please tell me about your lifestyle!

Patient Name: _____ *DOB:* _____

PERSONAL HABITS/RISK FACTORS	Doctor Notes <i>please do no write in this area</i>
<p>Dietary Habits: What is your diet like?: Please describe an average/representative day. Do you eat breakfast?</p> <p>What do you eat for: Lunch:</p> <p>Dinner:</p> <p>Snacks:</p> <p>Type and amount of Beverages/Water:</p> <p>Amount of Coffee/Alcohol :</p> <p>Dietary restrictions/allergies?</p> <p>Do you enjoy food? Do you cook?</p> <p>Exercise: Do you exercise regularly?(Type and Frequency) Do you feel better or worse after exercise? Do you enjoy your exercise? If you do not exercise, what do you feel is causing you not to do so?</p> <p>Sleep: Do you wake rested in the morning? How many hours of sleep do you get? Do you go to bed and wake up on a regular schedule.</p> <p>Social: Do you have positive relationships that you are satisfied with? Is your home a safe and comforting place? Does your job/career give you satisfaction? Do you feel joy in your life? What gives you happiness? Do you have enough time for yourself? Do you have positive self esteem?</p> <p>Negative Stress: What in your life is causing you significant stress? Do you feel isolated/without community? Do you have concerns about tobacco/drug/eating or other addictive issues?</p>	<p><i>If there are any special concerns you would like to discuss with the doctor, please continue on the reverse of this sheet. Thank you for providing us with this important information.</i></p>