



# SPECIALTY NATURAL MEDICINE INC PC Health Form

Date: \_\_\_\_\_

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

Birth date: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

### Present Health Concerns

Please list health concerns in their order of significance	What was the name of the past diagnosis of this problem?
1.	
2.	
3.	
4.	
5.	

Please list prescription medications that you are currently taking, with dose:

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

List vitamins, minerals, herbs, or any other non-prescription medications that you are currently taking, with dose:

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

**Please list any severe or life-threatening allergies:** \_\_\_\_\_

### Personal Habits

Please check any of the following substances that you use daily:

<input type="checkbox"/> Tobacco	<input type="checkbox"/> Coffee/Black Tea/Cola
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Recreational Drugs

Do you exercise regularly?  No  Yes    What Type of exercise? \_\_\_\_\_  
 How long each time? \_\_\_\_\_    How often per week? \_\_\_\_\_

Do you sleep through the night?  Yes  No    How many hours on average do you sleep nightly? \_\_\_\_\_

Would you consider yourself under excessive stress? \_\_\_\_\_    Are you willing to make changes? \_\_\_\_\_

## Past Medical History

Hospitalizations for: \_\_\_\_\_ Dates: \_\_\_\_\_

Serious Illnesses/ Injuries: \_\_\_\_\_

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

## Personal & Family History

Please check the "yes" box next to each condition that applies to you or one of your family members. Write the type of relation or write self in the "relation" box.

	YES	RELATION		YES	RELATION
Alcoholism/Drug Addiction			Headaches		
Allergies			Heart Disease		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Asthma			Kidney Disease		
Cancer			Mental Illness		
Depression			Stroke		
Diabetes			Tuberculosis		
Eczema			Other		
Epilepsy			Other		

## Social History

Please check those that apply:  Single  Married  Partner/Significant Other

Do you have any children?  Yes  No Age(s)/Name(s): \_\_\_\_\_

## Review of Systems

Please check any of the following that apply to you

Fatigue		Excessive Thirst		Unusual weight gain or loss	
Unusual nighttime perspiration		Rashes or Itching		Sores that do not heal	
Unusually dry skin		Unusual new skin growths		Blurred vision	
Glaucoma		Eye pain		Recent changes in vision	
Trouble hearing		ringing in the ears		Congestion	
Post nasal drip		Earaches		Frequent nosebleeds	
Persistent hoarseness		Sore tongue or mouth		Bleeding gums	
Frequent colds or flu		Constant cough		Coughing up blood	
Difficulty breathing		Chest pain		Ankle swelling	
Irregular heartbeat		Muscle cramps		Cold hands or feet	
Frequent Urinary infections		Burning urination or unusual discharge		Involuntary urination (with coughing)	
Blood in urine		Prostate trouble (men only)		Back pain	
Joint swelling or stiffness		Frequent or severe headaches		Frequent fainting or lightheadedness	
Double vision		Difficulty with memory		Convulsions or seizures	
Numbness or tingling in arms or legs		Nervousness		Unusual fevers	

## Women Only answer question or answer yes or no

Age of start of menstrual cycle		Are your cycles consistent number days		Average number of days between bleeds	
Average number of days of bleed		Do you bleed/spot between cycles		Are bleeds excessively heavy/with clots	
Do you have unusual pain with bleed		Do you use contraception?		Type of contraception:	
Hot flashes or night sweats		Past menopause		Age at menopause	
Bleeding after menopause		Nipple discharge			