Arizona Prohealth

The Health Improvement Clinic

Patient Information & Confidential Medical History

Today's date:_____

Name: _____ Birthdate: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell Phone: _____

Email Address: _____

Occupation:_____ Place of Work: _____

Emergency Contact Name: _____ Phone: _____

Name of Family Doctor: _____ Phone: _____

Reason for Visit: _____

MEDICATIONS/SUPPLEMENTS

Name of Medicine	Dosage	Frequency
(Example): Tylenol	250mg	Once daily

PERSONAL HISTORY & RISK FACTORS

(Please place an "X" by all that apply for you)

PAST & CURRENT MEDICAL HISTORY

- Hepatitis
- Thyroid disease
- Kidney disease
- Measles
- Mumps
- Chickenpox
- Smallpox
- Cancer
- Heart disease
- Diabetes
- Auto-Immune disease
- Arthritis

HEAD & NECK

- Headaches
- Cataracts
- Failing Vision
- Double Vision
- Visual "Floaters"
- Visual Loss
- Glasses/Contacts
- Hearing Loss
- Ringing in the ears
- Pain in the ears
- Discharge from the ears
- Nosebleeds
- Teeth Problems
- Root Canals
- Sinus Congestion
- Runny nose
- Frequent Colds
- Tongue problems
- Gum problems
- Voice problems
- Swelling in the neck
- Sinusitis

CARDIOVASCULAR

- Heart attack
- Stroke
- Angioplasty
- Heart Surgery
- Atherosclerosis
- Hypertension
- Arrhythmia
- Chest pain on effort
- Swelling Ankles
- Irregular heart beats
- High Cholesterol
- Angina

PULMONARY

- Cough
- Wheezing
- Tuberculosis
- Bronchitis
- Emphysema
- Asthma
- Pneumonia
- Valley Fever
- Sit up to breathe easier
- Spit up blook
- Chest Colds
- Shortness of Breath

SKIN

- Dryness
- Oily skin
- Itching
- Rashes
- Acne
- Discoloration
- Psoriasis
- Eczema
- Hives

GASTROINTESTINAL

- Abdominal pain
- Nausea
- Heartburn
- Indigestion
- Diarrhea
- Constipation
- Ulcers
- Liver Problems
- Appetite loss
- Irregular bowel movement
- Days without bowel movement
- Black tarry stools
- Bloating
- Clay colored stools
- Hemorrhoids
- Blood in stool
- Vomiting
- Gas

GENITOURINARY

- Frequent urination
- Excessive urination
- Scanty urination
- Retention of urine
- Incontinence
- Bedwetting
- Leakage of urine
  - Sneezing
  - Coughing
  - Exercise
- Pain with urination
- Burning urination
- Urination during the night
- Difficulty starting urination
- Dribbling after urination
- Blood in urine
- Kidney stones

MUSCOLOSKELETAL

- Back Pain
- Joint problems
- Muscle problems
- Weakness
- Disabled
- Tingling
- Numbness
- Balance problems
- Body aches & Pain
- Fatigue
- Weight loss

NEUROLOGICAL/PSYCHOLOGICAL

- Depression
- Nervous Breakdown
- Dizziness
- Lightheaded
- Fainting
- Paralysis
- Memory Loss
- Personality Changes
- Speech disturbances
- Counseling
- Alcohol problems
- Drug Problems
- Epilepsy
- Seizures
- Alzheimer's
- Dementia
- Parkinson's

OB/GYN

- Menopause
- Hot Flashes
- PMS
- Vaginal discharge
- Vaginal Dryness
- Painful Intercourse
- Decrease Libido
- Painful periods
- Missed periods
- Bleed between periods
- Excessive menstruation
- Cramping
- Clots
- Yeast infections
- Breast tenderness
- Breast discharge
- Breast lumps
- Birth control
- Regular PAP
- Currently pregnant
- Pregnant in past
- Abortion
- Miscarriage

DIETARY

(Mark what you are eating now)

- Coffee
- Tea
- Soda
- Beer
- Wine
- Liquor
- Candy
- Fried Foods
- Fast Foods
- Breads
- Chips
- Margarine
- Vegetables
- Fruit
- Cakes
- Cookies
- Pies
- Beef
- Fish
- Chicken
- Turkey
- Grains
- Milk
- Cheese
- Wheat
- Corn

Do you exercise? _____ If yest how often? _____

Do you consider yourself overweight? _____ How much? _____

Do you use recreational drugs? _____ If so, what? _____

Do you practice stress management/relaxation techniques? _____ What kind? _____

What is you stress level? (0=none, 10=extreme): 0 1 2 3 4 5 6 7 8 9 10

Are you now or have you ever been a cigarette smoker? _____ Packs a Day: _____ Years smoked: _____ If you quit, when?_____ Do you want to quit? _____

FAMILY HISTORY

Please list ages, health problems and if deceased, cause of death

Relationship	Age	Health Problems	Age of Death	Cause of Death
Father				
Mother				
Brother(s)				
Sisters(S)				

Please list any operations, major illnesses, and hospitalizations with approximate date:

_____

_____

Please check any know allergies or hypersensitivities:

_____

_____

What events or experiences have transpired for you that have led to your decision to pursue Naturopathic Medical Care?

_____

_____

_____

How did you learn about us or who referred you to us?

_____

MEDICAL GOALS

List the top four goals you wish to achieve regarding your health and general well-being.

1._____

2. _____

3. _____

4. _____

Is there any other information that was not covered in this questionnaire that you feel is important to comment on? _____ If yes, please explain:

_____

_____

PLEASE READ AND SIGN YOUR NAME

I _____ understand that Arizona ProHealth, LLC is a fee for service, cash based medical office and does not currently accept insurance coverage. I understand that I may submit to Superbill received from this office to my insurance company for financial reimbursement. I clearly understand and agree that all services rendered to me are charged directly tome and that I am personally responsible for payment on the day services are rendered. Methods of payment received are Visa, Mastercard, Discover, American Express, Personal Check and Cash.

Print your name: _____

Sign your name: _____

Today's Date: _____

Office Use Only

- Insurance copies (if needed)
- New Patient deposit received
- Laboratory Policy received
- Medical Results Initial Intake Complete
- Distribution Received
- Newsletter and Text Consent Received
- IV Consent Received
- Membership Docs Received

File Preparer: _____