Dr. Navi Badesha **Naturopathic Physician**

Patient Profile

Name____ **Age**______ **Birthday**___ **Sex**___
____

Address____ **City**___________________**Postal code**
_

Phone # (home)___________________________(work)____________________________(cell)___
____

Occupation____ **referred by**____

contact in case of Emergency____ phone#

Present Health Concerns *list in order of significance*

1. ____ 5. ___
2. ____ 6. ___
3. ____ 7. _______
4. ____ 8. __

Health as a child? Good___________ Fair _________ Poor__________

Hospitalizations *(year & reasons)*_____

Surgeries *(year & type)*______________

Serious illness or injury *(year & cause)*______

Vaccinations- all childhood? Yes_______ No______ Other (year, type, adverse reactions)___

Medications c*ircle any you are taking*

Antacids Anti diabetic/Insulin Antibiotic/Antifungal Anti-Inflammatory Cortisone High blood pressure Laxatives

Antidepressants Relaxants/Sleeping pills Radiation Aspirin/Tylenol Lithium Thyroid Chemotherapy Heart Medications

Oral Contraceptives Hormones Ulcer Medications Other

Allergies *list any allergies and what happens when you have an allergy attack*

Drugs_

Foods_

Other_

Please circle the following

Do you crave: Starches Y N Sweets Y N Salt Y N Fat Y N Are you a vegetarian Y N Vegan Y N

Blood Type________ Do you enjoy your work Y N Type of exercise you do/get_____

Do you: Sleep well Y N Wake rested Y N Average hours of sleep per night is ___

Do you use: Alcohol Y N Tobacco or live(d) with a smoker Y N Caffeine Y N Past

Recreational drugs Y N Occupational exposure to chemicals Y N Type_

Review of Systems Please circle: Yes - a condition you have now

No - never had

Past - a condition you have had in the past

General

Weight _________

Height _________

Night sweats Y N P

Fatigue Y N P

Skin

Rashes or Infections Y N P

Growths Y N P

Changes in hair/nails	Y	N	P

Head

Headache	Y	N	P
Head Injury	Y	N	P

Eyes

Impaired vision	Y	N	P
Eye pain	Y	N	P
Tearing	Y	N	P
Dryness	Y	N	P

Ears

Impaired hearing	Y	N	P
Ringing	Y	N	P
Earache/Itch	Y	N	P
Dizziness	Y	N	P

Nose & Sinuses

Frequent colds	Y	N	P
Nose bleeds	Y	N	P
Stuffiness	Y	N	P
Sinus Problems	Y	N	P
Post nasal drip	Y	N	P

Mouth & throat

Frequent sore throat	Y	N	P
Sore tongue	Y	N	P

Sore mouth and lips	Y	N	P
Gum problems	Y	N	P
Hoarseness	Y	N	P
Dental problems	Y	N	P
Root canals	Y	N	#___

Neck

Swollen glands	Y	N	P
Pain or stiffness	Y	N	P

Blood

Anemia	Y	N	P
Easy bleeding or bruising	Y	N	P

Respiratory

Cough	Y	N	P
Spitting up blood	Y	N	P
Wheezing	Y	N	P
Pain on breathing	Y	N	P
Shortness of breath	Y	N	P
Positive TB test ever	Y	N	P

Heart

Heart disease	Y	N	P
High blood pressure	Y	N	P
Rheumatic fever	Y	N	P
Chest pain	Y	N	P
Swelling in ankles	Y	N	P

Palpitations/fluttering Y N P

Digestion

Trouble swallowing Y N P

Heartburn Y N P

Stomach pain Y N P

Change in thirst Y N P

Change in appetite Y N P

Nausea or vomiting Y N P

Bowels move daily Y N P

Loose stools Y N P

Blood in stools Y N P

Bowel gas Y N P

Bloating Y N P

Belching Y N P

Liver/gall bladder disease Y N P

Hemorrhoids Y N P

Emotional

Depression Y N P

Mood swings Y N P

Anxiety or nervousness Y N P

Neurologic

Fainting Y N P

Seizures Y N P

Paralysis Y N P

Numbness or tingling Y N P

Loss of memory Y N P

Musculoskeletal

Joint pain or stiffness Y N P

Broken bones Y N P

Muscle spasms/cramps Y N P

Weakness Y N P

Urinary

Pain on urination Y N P

Increased frequency Y N P

Frequency at night Y N P

Urgency Y N P

Inability to hold urine Y N P

Bladder infections Y N P

Difficulty urinating Y N P

Circulation

Deep leg pain Y N P

Cold hands/feet Y N P

Varicose veins Y N P

Endocrine

Ever any thyroid problem Y N P

Heat or cold intolerance Y N P

Hypoglycemia Y N P

Excessive thirst Y N P

East weight gain Y N P

Male Reproduction (*men only*)

Hernias Y N P

Testicular masses Y N P

Testicular pain Y N P

Are you sexually active Y N P

Sexual difficulties Y N P

Prostate problems Y N P

Venereal disease Y N P

Discharge of sores Y N P

Difficulty with urination Y N P

Birth control Y N P

What type ______________

Female Reproduction *(women only)*

Age menses started __________

# of days menstrual flow __________

Length of complete cycle __________

Bleeding between periods Y N P

Are cycles regular Y N P

Pain during intercourse Y N P

Cramps Y N P

Abnormal vaginal discharge Y N P

Excessive flow Y N P

PMS Y N P

Date of last PAP smear ___________

Abnormal PAP Y N P

Date of last menstrual period_________

# of pregnancies	________		
Number of miscarriages	________		
Birth control	Y	N	P
What type	________		
Difficulty conceiving	Y	N	P
Menopausal symptoms	Y	N	P
Are you sexually active	Y	N	P
Sexual difficulties	Y	N	P
Venereal disease	Y	N	P

Breasts

Do self exam regularly	Y	N	P
Lumps	Y	N	P

Mark any illnesses which you now have with (Y) or have had in the past (P);

Abcesses	_______
Acne	_______
AIDS	_______
Alcohol addiction	_______
Allergies	_______
Alopecia	_______
Anemia	_______
Arthritis	_______
Asthma	_______
Attempted suicide	_______
Back problems	_______

Benign breast tumor ________

Bleeding gums ________

Bronchitis ________

Cancer ________

Candida albicans ________

Cataracts ________

Chest pains ________

Chicken pox ________

Cirrhosis ________

Crohn’s disease ________

Depression ________

Diabetes ________

Diphtheria ________

Diverticulosis ________

Drug addiction ________

Ear infections ________

Eating disorder ________

Eczema ________

Emphysema ________

Endometriosis ________

Epilepsy ________

Excessive fatigue ________

Eye disease ________

Fainting or dizzy ________

Gallstones ________

Gastritis ________

Gingivitis ________

Glaucoma ________

Goiter ________

Gonorrhea ________

Gout ________

Hay fever ________

Hearing problems ________

Heart disease/stroke ________

Hemorrhoids ________

Hepatitis ________

Hernia ________

Herniated disc ________

Herpes ________

High blood pressure ________

Hypothyroidism ________

HIV ________

Insomnia ________

Jaundice ________

Kidney disease ________

Kidney stones ________

Liver disease ________

Low blood pressure ________

Lupus ________

Major surgery ________

Malaria ________

Measles ________

Meningitis ________

Mononucleosis ________

Multiple sclerosis ________

Mumps ________

Myopia ________

Nervous breakdown ________

Neurological disease ________

Obesity ________

Osteoporosis ________

Pancreatitis ________

Persistent cough ________

Pneumonia ________

Polio ________

Psoriasis ________

Rheumatic fever ________

Rheumatoid arthritis ________

Scarlet fever ________

Sciatica ________

Senility ________

Shingles ________

Skin ulcers ________

Skipped heartbeats ________

Stroke ________

Stomach ulcer ________

Syphilis ________

Tuberculosis ________

Thyroid disease ________

Ulcerative colitis ________

Vision problems ________

Other____

Please indicate any significant health conditions of other family members

____
____
____
____
____
____