Seasons Natural Healthcare, LLC
Cora Rivard, ND

Health History Questionnaire (Confidential)

Please take the time to fill out this questionnaire carefully and completely. If you are not sure how to answer a particular question, simply mark it with a "?." The completed form will greatly assist me in providing a thorough evaluation of your health.

Name:_____________________________ Age:_________ Date of Birth___________ Sex:______

Home Address: Street:_________________________ City_________________ State__________ Zip__________

Phone: Home ( ) _______________ Work: ( ) _____________ Email: __________________

Occupation:____

How did you hear about Seasons Natural Healthcare?___________________________________

Emergency Contact:______________________Relationship:______________Phone:______________________

Please list your health concerns, in order of importance to you.

1.____________________________________ 5.______________________________________

2.____________________________________ 6.______________________________________

3.____________________________________ 7.______________________________________

4.____________________________________ 8.______________________________________

On a scale of 1-10, how much change and effort are you willing to make in your lifestyle in order to improve your health? (10 being "the most willing.")

Are you allergic to any medications?____ If "yes," please list:_______________________________

____

What happens when you have an allergy attack to this medication?__________________________

List any other known allergies here (food, environmental):__________________________________

Current Medication List
Please list all pharmaceutical medications that you are currently taking, along with dosage and frequency. Please include any over the counter medications you may be taking, such as antacids, sleep aids, pain relievers, etc.

Medication	Dosage	Frequency

Current Supplement List
Please list all vitamins, minerals, herbs and homeopathics that you are currently taking, along with dosage and frequency.

Supplement	Dosage	Frequency

Seasons Natural Healthcare, LLC
43B Birch Street, Suite #3G, Derry, NH 03038
Phone: (603)736-7770 Fax (603) 218-6583

Do you currently have a primary care physician, or are you under the care of any medical specialists?
If so, please list:

Name/specialty:_________________________________ Phone:______________________

Name/specialty:_________________________________ Phone:______________________

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Hospitalizations, Surgeries and Special Studies. What types of hospitalizations, surgeries and/or special studies (x-ray, MRI, CT scan) have you had? Please list type and approximate date.

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____

____

____

____

Social History
Are you currently: (please check one)
Married____ Divorced____ Single____ Long-Term Relationship____ Widowed_____

Do you have a supportive relationship?_______

Have you traveled outside of the U.S. in the past year? Yes_____ No_____

If yes, where?_________________________

Health Behaviors
1. Do you exercise? _______ Any physical limitations to exercising?__________________

What kind of exercise do you do and how many times a week? __________________________

____

2. Past or present use of any tobacco products? (please check one of the following):

Current use_____ Quit_____ No______

How many/much per day__________ How many years?_______________

If no, any past use? _______ How much and for how many years?_____________________

3. Do you use any recreational drugs?________

4. How much of the following do you consume:

Alcohol: # of drinks per day__________ Coffee: # of cups per day____________

Black tea: # of cups per day___________ Soda: # of cans/ glasses per day_______

Water: # of glasses per day ___________

5. Do you follow any dietary modifications? If so, please describe.__________________________

6. Are you sexually active?____ If yes, what form(s) of contraception do you use?____

7. Date of last physical exam: ____________

8. Men: Date of last prostate exam:___________

9. Do you feel like you manage stress well? _________

	Yes, Currently	Yes, In Past	No
General			
Do you usually feel tired or worn out?			
Have you recently been more thirsty than normal?			
Has there been any unusual weight gain or loss recently?			
Do you perspire a lot?			
Do you often feel too warm or too cold, compared to others?			
(Circle one of the above, if applicable)			
Skin/Hair/Nails			
Have you noticed any changes in the color of your skin?			
Have you noticed any skin rashes or itching?			
Have you noticed any unusually dry skin?			
Have you noticed any growth on your skin that bothers you?			
Have you noticed any sores or wounds that do not heal?			
Have you noticed any change in color or size or warts?			
Do you have dry skin or brittle nails?			
Eyes			
Have you had any pain in your eyes?			
Have you had any blurry vision?			
Are you nearsighted or farsighted (circle one if applicable)			
Have you noticed any change in your vision?			
Do you often have itchy eyes?			
Have you noticed any redness or burning in your eyes?			
Do you see halos around lights?			
Ears, Nose, Throat			
Do you have any difficulty hearing?			
Do you have any ringing or buzzing in your ears?			
Do you have earaches or discharge from your ears?			
Do you have a lot of nasal stuffiness or sinusitis?			
Do you have drainage down the back of your throat?			
Do you experience frequent or severe nosebleeds?			
Do you have any lumps in your throat?			
Do you experience sore tongue or mouth?			
Do you have bleeding or easily infected gums?			
Do have excessive saliva?			
Do you have bad breath?			
Respiratory			
Do you have frequent chest colds?			
Do you have a constant or bothersome cough?			
Do you cough up blood?			
Do you have sputum or phlegm between colds?			
Do you have any difficulty breathing?			
Have you noticed any wheezing or whistling?			

	Yes, Currently	Yes, In Past	No
Cardiovascular			
Do you have pain, tightness or pressure in front or back of your chest?			
If yes, is it when walking fast, working hard or when excited?			
Have you ever had an abnormal EKG?			
Do you have swelling of your feet or ankles?			
Do you have cramps in the calf muscles when you walk?			
Do you need to sleep on more than one pillow?			
Does your heart ever beat fast or irregularly?			
Do your fingers or toes ever get cold, become numb or blue?			
Do you ever awaken at night with difficulty breathing?			
Gastrointestinal			
Have you recently had any change in your eating habits?			
Are there any foods that give you upset or pain?			
Have you recently experienced nausea or vomiting?			
Do you have excessive gas? (burping or passing gas?)			
Have you ever vomited blood?			
Do you have a lot of indigestion, heartburn or reflux?			
Have you recently experienced any trouble swallowing?			
Do you experience constipation?			
Do you experience diarrhea?			
Do you have a poor appetite or are easily satiated?			
Have you ever had blood in your stools?			
Do you have hemorrhoids?			
Do you take laxatives regularly?			
Do you feel bloated after meals?			
Do you experience abdominal pain or cramping?			
Genitourinary			
Do you have any burning or pain on urination?			
Do you have any change in frequency of urination?			
Have you experienced urinary incontinence?			
Do you get up at night to urinate?			
Do you have a problem dribbling urine?			
Have you ever passed blood in your urine?			
Do you have frequent bladder or kidney infections?			
Men, do you have prostate trouble?			
Men, have you ever experienced erectile dysfunction?			
Musculoskeletal			
Do you experience regular back pain?			
Do you have pain in your legs or feet?			
Have you ever been diagnosed with scoliosis?			
Do you have joint pain or stiffness?			
Do you have trouble walking or using your hip or knee joints?			
Do you experience regular pain in your body? (specify)			

Central Nervous System	Yes, Currently	Yes, In Past	No
Do you have frequent or severe headaches? lightheadedness?			
Do you sometimes lose track of what happens around you for a short time?			
Do you sometimes lose the ability to speak for a few seconds?			
Have you fainted, blacked out or lost consciousness?			
Do you consider yourself a nervous person?			
Do you have trouble remembering recent events?			
Have you ever had convulsions or fits?			
Do you experience insomnia?			
Have you been highly emotional lately?			
Psychological/mental status			
Do you experience depression?			
Do you experience anxiety or panic attacks?			
Have you ever been hospitalized for a psychological condition?			
Have you ever had any suicidal attempts?			
Do you have suicidal thoughts?			
Do you experience excessive restlessness?			
Do you experience mental confusion?			
Are you critical of yourself?			
Are you critical of others?			
Do you experience mood swings?			
Do you experience loneliness?			
Have you ever been diagnosed with a psychological condition?			

Please circle any of the following if present in your personal or family history (someone you are related to has had it):

Anemia Arthritis Asthma/Hay fever Cancer Chronic Fatigue

Diabetes Addiction Eating Disorder Epilepsy Eczema/Psoriasis

Glaucoma Heart Disease Hypertension Stroke Kidney Disease

Mental Illness Osteoporosis Thyroid Disease Tuberculosis

Women Only: Gynecology and Pregnancy

Please specify the number of: Births______ Miscarriages______ Abortions_______

Age at first period:_______ Age at Menopause________

Menopausal symptoms____

Regular or Irregular cycles? (circle one)

Duration of flow (days) ____________ Time between cycles_______________

Flow is (check one): ☐ Excessive ☐ Moderate ☐ Scanty

PMS (check one): ☐ Yes ☐ No

Symptoms:
____

Cramps (check one): ☐ Severe ☐ Mild ☐ None

Date of last period: _________________

Method of birth control:________________________________

Please check any/all that apply to you:

- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ History of Genital Warts
- ☐ Mother/ sister With breast Cancer
- ☐ Nipple discharge
- ☐ Pain during intercourse
- ☐ Pain during orgasm
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Vaginal itching
- ☐ Vulvar itching
- ☐ Water retention