Alethea Fleming, ND
Vital Aging Clinic
902 28th Street
Anacortes, WA 98221
www.vitalagingclinic.com
Tel. 360-630-3022

## Patient Health History Questionnaire

*Naturopathic healthcare is possible only when the physician fully understands the patient's physical, mental and emotional condition. The information you provide helps the doctor understand your needs and how to help you reach your health goals. Welcome!*

---

Patient's name: _____
(Last) (First) (Middle initial)

Mailing address: _____
Physical address (if different): _____

Best Phone(s): _____ Email: _____

Date of birth: _____ Age: _____ Gender: _____ Blood Type: _____

Occupation: _____ Social Security #: _____
(We collect social security numbers for the purpose of patient identification and compliance with federal and state agency reporting requirements. Disclosure of your social security number is voluntary.)

How did you hear about us? _____

What is your current living and relationship situation? _____

Emergency contact: _____
(Name) (Phone)
Relationship: _____

What are your most important health concerns in order of importance?
1.
2.
3.

Please list any current healthcare providers:
_____

When and where did you last receive healthcare? _____

What was the reason? _____

List any previous hospitalizations or surgeries:_____

List any prescription or over-the-counter medications or natural supplements that you are currently taking:

_____ _____

_____ _____

_____ _____

List any allergies that you have, including environmental, food or medication:

_____

Circle any of the following childhood illnesses that you have had:

Diphtheria Polio Measles Mumps Rubella Pertussis Chicken Pox Other_____

Mother's age or age at death: _____

Health condition: _____

Father's age or age at death: _____

Health condition: _____

List any health conditions that members of your immediate family (parents, siblings) may have, such as: *(cancer, diabetes, heart disease, hypertension, stroke, epilepsy, mental illness, asthma, hives, anemia, kidney disease, liver or gallbladder disease, ulcer, tuberculosis, goiter, arthritis, cataracts, glaucoma, etc):*

_____

_____

## General

Weight _____ Height _____ Weight 1 year ago _____ Max weight _____ When _____

## Habits

What are your main interests and hobbies?

Do you exercise? Y N

What form and how often?

| | | | | | |
|---|---|---|---|---|---|
| Do you eat three meals each day? | Y N | | | Awaken rested? | Y N |
| Average 6-8 hours sleep per day? | Y N | | | Sleep well? | Y N |
| Enjoy your work? | Y N | | | Take vacations? | Y N |
| Spend time outside? | Y N | Hours/day? | ____ | | |
| Read | Y N | | | Have a spiritual practice? | Y N |
| Watch television | Y N | Hours/day? | ____ | | |
| Use recreational drugs? | Y N | | | Been treated for drug dependence? | Y N |
| Use Alcoholic beverages? | Y N | | | Been treated for alcoholism? | Y N |
| Use tobacco? | Y N | | | | |

Signature: _____ Date: _____

*Thank You!*