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Adult Patient Profile

Please complete the following health history summary as thoroughly as possible.

Date: _____

Last name: _____ First name _____ Middle initial _____

Date of birth: _____ Age: _____ Gender _____

Address: _____ City: _____ State _____ Zip: _____

Home phone(____) _____ Work Phone(____) _____ E-Mail: _____

Emergency contact: _____ Relationship: _____ Phone: _____

How did you hear about this office? _____

Last physician(s) or health practitioner(s) seen? _____

When? _____

What is your main reason for coming in today? _____

Onset of condition? _____

Additional health concerns in order of importance:	Duration
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1. _____	_____
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2. _____	_____
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3. _____	_____
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Health History:

Average energy level 1-10 (1 lowest→10 highest) _____

Average stress level 1-10 (1 lowest→10 highest) _____

List the 4 most stressful events in your life from most recent. Do they continue to influence your life?

1. _____ when? _____
2. _____ when? _____
3. _____ when? _____
4. _____ when? _____

How do you handle stress? _____

Current Medications (Please list name of drug, dose and length of time used)

Vitamins and/or herbal supplements (dose, length of time used)

Have you had or currently have any of the following? (Please circle and include date)

Diabetes	_____	heart disease	_____	high cholesterol	_____
High blood pressure	_____	HIV	_____	stroke	_____
Kidney disease	_____	tuberculosis	_____	cancer(type(s))	_____
Arthritis	_____	anemia	_____	asthma	_____
Headaches	_____	epilepsy	_____	alcoholism	_____
Hepatitis (type)	_____	hyper/hypothyroid	_____	drug addiction	_____
Mental illness	_____	sinusitis	_____	yeast infections	_____
Sexually transmitted Disease	_____	other	_____		

Do you have any allergies to foods, drugs, herbal supplements, other?

Do you currently use any of the following? Please indicate how often and how much.

Alcohol _____
Tobacco _____
Caffeine _____
(coffee, tea, soft drinks)
Recreational drugs _____

Which childhood illness have you had?

	Date		Date		Date		Date
Measles	_____	Mumps	_____	Chickenpox	_____	Whooping Cough	_____
Polio	_____	Diphtheria	_____	Rheumatic fever	_____	Scarlet fever	_____
Smallpox	_____	Typhoid fever	_____	Tuberculosis	_____	Mono	_____

Other _____

Have you been vaccinated? Please list: _____

Have you ever been hospitalized? Had surgery? Please indicate date(s) and reason(s).

Diet

How often do you eat the following? (daily, weekly, rarely never)

Sweets _____

Dairy products _____

Red meat _____

Fresh fruits _____

Vegetables _____

Pasta _____

How many glasses of water do you drink each day? _____

Family History

Please indicate health problems of family members. If deceased, note cause of death and age.

Mother _____

Father _____

Brother(s) _____

Sister(s) _____

Maternal

Grandmother _____

Grandfather _____

Paternal

Grandmother _____

Grandfather _____

Personal Habits

Do you exercise? _____ How often/how long? _____

How do you spend your leisure time? _____

Hobbies? _____

Religious affiliation (if any) _____

Do you have problems falling asleep? _____ Staying asleep? _____

How many hours do you sleep each night? _____ Do you wake refreshed? _____

Social History (Please circle where applicable)

Single married divorced..... separated.....widowed.....committed relationship

You currently live with: spouse partner parents children friends alone pets

Your occupation: _____ Current education level _____

Are you exposed to fumes, chemicals, or second hand smoke at home or workplace?

Medical/Health History

Female:

Age of first menses _____ Date of last menses _____

Do you have regular cycles? If not, describe _____

Is your bleeding light, medium, heavy? Do you bleed between periods? _____

Do you have PMS? Describe _____

Number of pregnancies _____ Number of abortions _____ Number of live births _____

Type of delivery(s) _____

Date of last physical exam _____ Results _____

Date of last pelvic/PAP exam _____ Results _____

Date of last mammogram _____ Results _____

Do you perform self-breast exams? _____ How often? _____

Are you sexually active? _____ Type of birth control (if any) _____

Male

Date of last physical exam _____ Results _____

Date of last prostate exam _____ Results _____

Are you sexually active? _____ Type of birth control (if any) _____

Digestion and Elimination

Do you experience gas/bloating after meals? _____

How often do you have bowel movements? _____

Mucous, blood, undigested food? _____

Unusual odor or color? _____

Are stools formed, loose, hard? _____

Do you strain? _____

Pain or burning with urination? _____

Do you awaken at night to urinate? _____ If yes, how often? _____

Blood in urine or unusual color? _____

Additional comments:

Thank you for taking the time to complete this form

Acknowledgment Agreement

Arlene B. Donar, ND, MA graduated with a doctoral degree form the University of Bridgeport College of Naturopathic Medicine. UBCNM is one of only four nationally accredited naturopathic medical schools.

Dr. Donar has passed national medical boards and fulfilled all requirements for naturopathic licensure from the Department of Public Health in the state of Connecticut. At this time, New York does not offer licensing in this field of medicine.

Your signature below acknowledges that you have read and understand the above statement.

Signature

Date