Corina B. Going, ND

Naturopathic Physician ◆ Classical Homeopath

309 South G Street, Suite 4, Tacoma, WA 98405

19 Little Island Lane, Cathlamet, WA. 98612

(253) 341-9410 fax: (253) 442-6144

HEALTH HISTORY

Name_____ Date _____DOB _____

MEDICATIONS

List all current medications (prescription and nonprescription drugs), herbs and supplements with dosages.

_____

_____

_____

_____

ALLERGIES

List any allergies you have to drugs, food or environmental agents. Please indicate what type of reaction you have.

_____

_____

CHILDHOOD HEALTH

Generally described as (please check) ☐ Good ☐ Fair ☐ Poor

Please indicate which, if any, of the following illnesses you have had.

☐ Asthma	☐ German measles	☐ Mumps	☐ Whooping cough
☐ Scarlet fever	☐ Hepatitis	☐ Chicken pox	☐ Rheumatic fever
☐ Diphtheria	☐ Measles		

Vaccinations: (year, type, adverse reactions?) _____

_____

HABITS/LIFESTYLE

Please circle and/or give a brief description where indicated

Alcohol: How much?_____ How often? _____

Tobacco: Type: ☐ smoke or ☐ chew How long used? _____

Caffeine: How much? _____

Recreational drugs: How much? _____ How long used? _____

Diet restrictions _____

Food cravings _____

Exercise program _____

Average hours of sleep _____ Do you wake rested? ☐ Yes ☐ No

Do you sleep well? _____

Occupation _____ Do you like your job? ☐ Yes ☐ No

Stress level (home/job/other)_____

Living situation (house/apt, number in household, etc.) _____

_____

Single/Committed relationship/Married/Divorced (please circle the situation that applies to you)

Social life/activities _____

Spiritual practice _____

FAMILY HISTORY

Fill in all that apply

	Father	Mother	Brother(s)	Sister(s)	Spouse	Other
Age (if living)						
Age at death						
General health						
Alcoholism						
Allergies						
Anemia						
Asthma						
Cancer						
Diabetes						
Epilepsy						
Glaucoma						
Heart disease						
Hepatitis						
High blood pressure						
Kidney disease						
Mental illness						
Stroke						
Tuberculosis						
Other (describe)						
Other (describe)						

PERSONAL HISTORY

Check any of the following illness that you have had.

- ☐ Mononucleosis
- ☐ Rheumatic fever
- ☐ Angina pectoris
- ☐ Heart attack
- ☐ Other heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Gout
- ☐ Anemia
- ☐ Hay fever
- ☐ Asthma
- ☐ Frequent lung infections
- ☐ Emphysema
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Freq kidney/bladder infections
- ☐ Nervous breakdown
- ☐ Depression
- ☐ Alcoholism
- ☐ Stomach ulcer
- ☐ Colitis
- ☐ Gallbladder disease
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Migraine headache
- ☐ Thyroid disease
- ☐ Sexually transmitted disease
- ☐ HIV or AIDS

Other _____

List all operations and approximate date _____

_____

_____

List all hospitalizations (other than operations) with reason admitted and approximate date

_____

_____

List all serious injuries (other than above) with approximate date _____

_____

_____

GENERAL HEALTH

Date of last physical exam _____ dental exam_____ eye exam_____
Weight _____ Weight 1 year ago _____
Height _____

REVIEW OF SYSTEMS

Chwxk which, if any, of the following symptoms you currently have.

- ☐ Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Weight loss or gain (unexplained)
- ☐ Swollen glands
- ☐ Insomnia
- ☐ Anxiety/depression
- ☐ Appetite or thirst changes
- ☐ Night sweats
- ☐ Cold hands/feet
- ☐ Itching
- ☐ Rashes
- ☐ Skin growths
- ☐ Slow wound healing
- ☐ Headache
- ☐ Hair loss/weak nails
- ☐ Eye pain
- ☐ Vision changes
- ☐ Hearing changes
- ☐ Ringing/buzzing in ear
- ☐ Earaches/discharge
- ☐ Nasal discharge
- ☐ Nosebleeds
- ☐ Sinus problems
- ☐ Frequent sore throats
- ☐ Persistent hoarseness
- ☐ Lump in the throat
- ☐ Sore tongue or mouth
- ☐ Bleeding gums
- ☐ Dental problems
- ☐ Frequent chest colds
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Short of breath
- ☐ Short of breath at night
- ☐ Irregular heart beat
- ☐ Chest pain/tightness
- ☐ Swelling feet/ankles
- ☐ Easy bruising
- ☐ Blood clots/phlebitis
- ☐ Abdominal discomfort
- ☐ Burping
- ☐ Difficulty swallowing
- ☐ Indigestion/heartburn
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Change in bowel habit
- ☐ Hemorrhoids
- ☐ Bleeding from rectum
- ☐ Black or tarry stool
- ☐ Nausea
- ☐ Bloating/gas
- ☐ Rectal pain
- ☐ Frequent urination
- ☐ Large amount of urine
- ☐ Pain with urination
- ☐ Urinate at night
- ☐ Trouble urinating
- ☐ Dribbling urine
- ☐ Lose urine when coughing
- ☐ Genital sores
- ☐ Genital discharge
- ☐ Pain during intercourse
- ☐ Memory changes
- ☐ Seizures
- ☐ Fainting
- ☐ Coordination changes
- ☐ Changes in strength
- ☐ Numbness/tingling
- ☐ Neck/back pain
- ☐ Muscle pain
- ☐ Joint pain

For women only

Age menses began _____ Last menstrual period _____
Length of menses _____ Number of pregnancies_____
Type of birth control used _____ Number of abortions _____
Type of STD protection used_____ Number of miscarriages _____
Last breast exam/pap _____ Normal? ☐ Yes ☐ No
If not, describe _____

Check which, if any, of the following symptoms you currently have

- ☐ Vaginal discharge
- ☐ Pain with intercourse
- ☐ Painful menses
- ☐ Heavy menses
- ☐ Missed menses
- ☐ Bleed btwn menses
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Nipple discharge

For men only

Date of last prostate exam_____ Normal? If not, describe _____
Type of birth control used _____ ☐ Yes ☐ No
Type of STD protection used_____