LAKE NATURAL MEDICINE
Dr. Gregory L. McDonald, ND, LAc
311 B Avenue, Suite L
Lake Oswego, OR 97034

ph (503) 699-6636
fax (844) 270-0696

Medical Health History

Patient Name: _____ **Date of Birth:** ____/____/____

Current Health Issues

Major health complaint _____

Other treatment received for this _____

Are there other family members with the same condition? _____

Is this related to a Work injury? _____ Car accident? _____ Date of injury ___/___/___

Does this problem interfere with your daily activities? If so, how? _____

_____

Other current health concerns / complaints _____

Prescription or over-the-counter Medications you now take (list all) _____

_____

Vitamins, supplements, herbs, remedies _____

_____

Have you previously sought complementary health care? Please check:

___Naturopathy ___Acupuncture ___Chiropractic ___Osteopathy ___Massage/Shiatsu/Bodywork

___Other _____

Health History (include dates)

Major illnesses _____

Surgeries / hospitalizations _____

Other significant trauma _____

Have you been treated for any health condition in the past year? ___Yes ___No

If yes, please explain _____

Allergies (drugs, chemicals, foods) _____

Do you drink alcohol? _____ average # drinks/day _____ Do you smoke? _____ # packs/day _____

Do you take recreational drugs? Yes ___ No ___ Do you have a pacemaker? Yes ___ No ___

Family Medical History (check all that apply to blood-related family members)

___ Diabetes	___ Cancer	___ Heart disease	___ Stroke
___ High cholesterol	___ High blood pressure	___ Mental disorders	___ Thyroid problems
___ Asthma	___ Allergies	___ Alcoholism	___ Back problems

___ Other family diseases _____

(OVER --->)

Have you ever had any of these diseases? (please check)

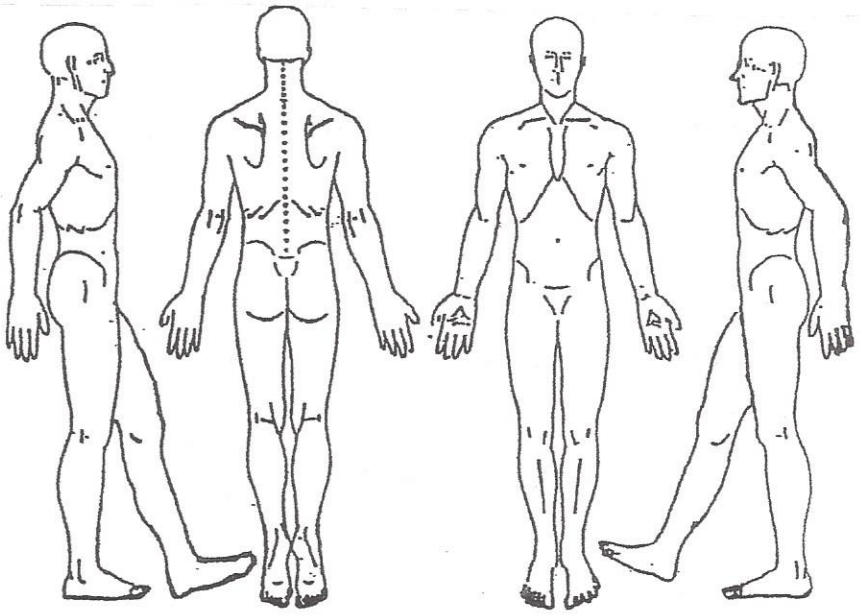
___ Appendicitis
___ Tuberculosis
___ Cancer
___ High cholesterol
___ Pneumonia
___ Rheumatic fever
___ Asthma
___ Mononucleosis
___ Malaria
___ Diabetes
___ Epilepsy
___ Parkinson's
___ Measles
___ Mumps
___ Lupus
___ Chicken Pox
___ Heart disease
___ Arthritis
___ Anemia
___ Pleurisy
___ Goiter
___ Influenza
___ Colitis/IBS
___ Other _____
___ Alcoholism
___ Whooping cough
___ Eczema
___ Psoriasis
___ Rosacea
___ Mental disorder
___ Sexually transmitted

Symptoms & Conditions (please check those you've had within the last year)

Musculo-Skeletal

___ Headaches
___ Low back pain
___ Neck pain
___ Arm pain
___ Pain between shoulders
___ Joint pain/stiffness
___ Joint replacement _____(which joints?)
___ Walking problems
___ Cold/tingling extremities
___ Jaw pain/clicking

Shade in or Mark Areas of Your Discomfort



Nervous System

___ Numbness
___ Dizziness
___ Fainting
___ Convulsions

Cardio & Vascular

___ Chest pain
___ Shortness of breath
___ BP problems
___ Palpations/Irregular beat
___ Ankle swelling
___ Varicose veins

Respiratory

___ Bronchitis
___ Congestion
___ Dry cough
___ Productive cough
___ Wheezing
___ Asthma

Mental/Emotional

___ Addiction concerns
___ Depression
___ Anxiousness
___ Panic attacks
___ Confusion
___ Forgetfulness

Ear/Nose/Throat

___ Ringing ears
___ Ear aches
___ Sore throat
___ Hearing difficulty
___ Dental problems
___ Stuffed/runny nose

Skin

___ Rash
___ Hives
___ Redness
___ Numbness
___ Itching
___ Burning
Other _____

General

___ Allergies (seasonal)
___ Insomnia
___ Fever
___ Migraines
___ Thyroid problems (explain) _____
___ Vision problems

Genito-Urinary

___ Urinary tract infection
___ Blood in urine
___ Excessive urination

Gastro-Intestinal

___ Poor appetite
___ Excessive appetite
___ Nausea
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Liver problems
___ Abdominal cramps
___ Gas/bloating after meals
___ Heartburn/indigestion
___ Gall bladder problems
___ Black/bloody stool
# of Bowel Movements per day _____

Female Only

___ Menstrual irregularity
___ Menstrual cramping
___ Vaginal infection/pain
___ Breast pain/lumps
___ Ovarian pain
___ Discharge between periods
___ Premenstrual tension (PMS)
___ Hot flashes/night sweats
___ Hysterectomy
___ Lack of libido

Male Only

___ Prostrate problems
___ Difficulty in urination
___ Nighttime urination (# times? ___)
___ Sexual dysfunction
___ Lack of libido

Are you Pregnant? Yes ___ No ___ What is your due date? _____ Breastfeeding? Yes ___ No ___
Are you still menstruating? ___ Yes ___ No (Age you stopped: _____)
Age when menstruation started _____ # Days between cycles (usually) _____
Days of flow (usually) _____ Maximum # pads/tampon changes per day _____
Date of last period _____
Any tendency to: ___ Heavier periods ___ Longer periods ___ Scantier periods
Quality of Blood: ___ Bright red ___ Dark red ___ Clots
# of Pregnancies _____ Date of last PAP smear _____ Method of Contraception _____
# of Live Babies _____ Date of last Mammogram _____
# of Miscarriages _____ # of D&C's _____ # of Caesarian births _____

Patient (or Guardian) Signature: _____
Date: ____/____/____