Catherine M. Gurski, ND, MSOM, LAc.
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Patient Health History

Patient's name: ____
Please Print (Last) (Middle) (First)

Address: ____
Street or POB

____
City, State, Zip

Phone: ______________________ Email: ______________________
Home

______________________ Cell: ______________________
Work with extension

Date of Birth: ________________ Age: _____ Female: _____ Male: _____

Preferred Name: __________________

Occupation: ______________________ Employer: ________________

Emergency Contact: __________________ Relationship: ______________

Phone: ___________________________

How many children do you have? ____________________

Social: _____single _____married _____other _____separated _____divorced

Living with: ______spouse _____friends _____roommates _____parents

_____children ______children part-time _____alone ______other

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How did you hear about me? ____From a friend ____Flyer ____Website

____Practitioner/Doctor ____Business card ___Other:_______________

Please check any services that you are interested in now or in the future.

____Massage ____Shiatsu ____Acupuncture ____Herbal Medicine
____Naturopathic Medicine ____Counseling ____CranioSacral
____Sports Medicine ____Meditation ____Qi Gong

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When did you last go to a doctor's office, medical office or hospital? What was the reason?

What are your most important health concerns?

What hospitalizations or surgeries have you had?

What diagnostic imaging have you had?

_____EKG ______Ultrasound ______MRI ______X-rays ______mammogram

_____CT ______Bone Density (DEXA) other ______________________________

Please list all current medications and supplements:

Please check any of the following that you currently take:

___Pain Relievers (Aspirin/Tylenol/Advil)
___Hormone Replacement Medication ____Hormonal Birth Control
___Cortisone (cream or pills)

___Thyroid medication
___Sleep aids
___Antacids (Rolaids/Tums)
___Laxatives
___Anti-anxiety ____Antidepressants _____Anticonvulsants/Antiseizure

Do you have allergies to foods, drugs, animals, pollens, etc.? Please list: ____________

____

Please check the immunizations that you have had? Place a (?) if you do not know.

____Diptheria ____Measles/Mumps/Rubella ____Polio ____Pertussis ___Tetanus

Have you had the following illnesses?

Scarlet Fever	yes	no
Diptheria	yes	no
Rheumatic Fever	yes	no
Mumps	yes	no
Measles	yes	no
German Measles	yes	no

Other ____

Please check any of the following that you or your family members have experienced:

Cancer ___self ___father ___mother ____brother ___sister ___children

Diabetes ___self ___father ____mother ____brother ____sister ____children

Heart Disease ___self ___father ____mother ____brother ___sister ____children

High Blood Pressure ___self ___father ___mother ___brother ____sister ___children

Stroke ____self ____father ____mother ____brother ____sister ____children

Epilepsy ____self ____father ____mother ____brother ____sister ____children

Mental Illness ____self ____father ____mother ____brother ____sister ____children

Asthma ____self ____father ____mother ____brother ____sister ____children

Hay fever/Hives ____self ____father ____mother ___brother ___sister ___children

Anemia ____self ____father ____mother ____brother ____sister ____children

Kidney Disease ___self ___father ___mother ___brother ___sister ___children

Liver Disease ___self ___father ___mother ___brother ___sister ___children

Gallbladder Dz ___self ___father ___mother ___brother ___sister ___children

Ulcer ___self ___father ___mother ___brother ___sister ____children

Tuberculosis ___self ___father ___mother ___brother ___sister ____children

Goiter ___self ___father ___mother ___brother ___sister ____children

Arthritis ___self ___father ___mother ___brother ___sister ____children

Heart Murmur ___self ___father ___mother ___brother ___sister ___children

Cataracts ___self ___father ___mother ___brother ___sister ____children

Glaucoma ___self ___father ___mother ___brother ___sister ____children

GENERAL

Weight_____ Weight one year ago______ Height_____

Energy Level_____ (0—5) 0 = none 5 = excess

What are you hobbies and interests? ________________________________

Do you exercise and if so how many days per week? ________________________________

What type of exercise do you do? ________________________________

____

____

Do you eat three meals a day? ___ yes ___ no
Do you sleep well? ___ yes ___ no
Do you awake rested? ___ yes ___ no
Do you average 6 to 8 hours of sleep? ___ yes ___ no
Do you enjoy your work? ___ yes ___ no
Do you spend time outside? ___ yes ___ no
Do you take vacations? ___ yes ___ no

How many hours of TV do you watch per day? _______

Do you use recreational drugs?	___ yes	___ no
Do you use tobacco?	___ yes	___ no
Do you drink alcoholic beverages?	___ yes	___ no
Have you been treated for alcoholism?	___ yes	___ no
Have you been treated for drug dependence?	___ yes	___ no

REVIEW OF SYSTEMS

Circle the response that applies **Y = present condition** **P = past condition** **N = never a condition**

SKIN

Rashes	Y	P	N
Eczema/Hives	Y	P	N
Acne/Boils	Y	P	N
Itching	Y	P	N
Color change	Y	P	N
Lumps	Y	P	N
Night Sweats	Y	P	N

HEAD

Headache	Y	P	N
Head Injury	Y	P	N
Migraines	Y	P	N

EYES

Impaired vision	Y	P	N
Glasses/contacts	Y	P	N
Eye Pain	Y	P	N
Tearing/dryness	Y	P	N
Double vision	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N

EARS

Impaired hearing	Y	P	N
Ringing	Y	P	N
Earache	Y	P	N
Dizziness	Y	P	N

NOSE/SINUSES

Frequent colds	Y	P	N
Nose bleeds	Y	P	N
Stuffiness	Y	P	N
Hay Fever	Y	P	N
Sinus problems	Y	P	N

MOUTH/THROAT

Many sore throats	Y	P	N
Sore tongue	Y	P	N
Canker sores	Y	P	N
Gum Problems	Y	P	N
Hoarseness	Y	P	N

NECK

Lumps	Y	P	N
Swollen glands	Y	P	N
Goiter	Y	P	N
Pain/Stiffness	Y	P	N

RESPIRATORY

Cough	Y	P	N
Sputum	Y	P	N
Spitting blood	Y	P	N
Wheezing	Y	P	N

URINARY

Pain on urination	Y	P	N
Increased frequency	Y	P	N
Frequency at night	Y	P	N
Inability to hold urine	Y	P	N
Frequent infections	Y	P	N
Kidney stones	Y	P	N

FEMALE REPRODUCTIVE

Age menses began	_________		
Average number days	_________		
Length of cycle	_________ days		
Age of last menses	_________		
Bleeding between periods	Y	P	N
Are cycles regular	Y	P	N
Painful menses	Y	P	N
Excessive flow	Y	P	N
Painful intercourse	Y	P	N
Type of Birth Control	___________		
Number of Pregnancies	___________		
Number of live births	___________		
Number of miscarriages	___________		
Number of abortions	___________		
Difficulty conceiving	Yes	No	
Menopausal symptoms	Y	P	N
Breasts lumps	Y	P	N
Breast pain/tenderness	Y	P	N
Nipple discharge	Y	P	N
Perform self breast exam	Y	P	N
Date of last menses	Y	P	N
Sexually active	Y	P	N
Sexual difficulties	Y	P	N
Venereal disease	Y	P	N
Sexual Preference	Y	P	N

___Hetero ____Bi ___Homosexual

MALEREPRODUCTIVE

Hernias	Y	P	N
Testicular masses	Y	P	N
Sexually active	Y	P	N
Sexual difficulties	Y	P	N
Prostate disease	Y	P	N
Venereal disease	Y	P	N
Discharge or sores	Y	P	N

Sexual preference

___Hetero ___Bi ____Homosexual

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RESPIRATORY

Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Pleurisy	Y	P	N
Emphysema	Y	P	N
Difficult breathing	Y	P	N
Shortness of breath	Y	P	N
at night	Y	P	N
lying down	Y	P	N
Tuberculosis	Y	P	N

CARDIOVASCULAR

Heart disease	Y	P	N
Angina	Y	P	N
High BP	Y	P	N
Murmurs	Y	P	N
Rheumatic fever	Y	P	N
Chest Pain	Y	P	N
Palpitations	Y	P	N
Swelling in ankles	Y	P	N

GASTROINTESTINAL

Trouble swallowing	Y	P	N
Heartburn	Y	P	N
Change in thirst	Y	P	N
Change in appetite	Y	P	N
Nausea	Y	P	N
Vomiting blood	Y	P	N

Bowel movements—how often? ______
Is this a change? Yes No

Blood in stool	Y	P	N
Belching/gas	Y	P	N
Jaundice(yellow skin)	Y	P	N
Liver disease	Y	P	N
Hemorrhoids	Y	P	N

NEUROLOGIC

Fainting	Y	P	N
Seizures	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness/tingling	Y	P	N
Loss of memory	Y	P	N

MUSCUL0SKELETAL

Joint pain or stiffness	Y	P	N
Arthritis	Y	P	N
Broken Bones	Y	P	N
Muscle spasms/cramps	Y	P	N
Weakness	Y	P	N

PERIPHERAL VASCULAR

Deep leg pain	Y	P	N
Cold hands/feet	Y	P	N
Varicose veins	Y	P	N
Thrombophlebitis	Y	P	N

EMOTIONAL

Depression	Y	P	N
Mood swings	Y	P	N
Anxiety/nervousness	Y	P	N
Tension	Y	P	N

ENDOCRINE

Hypothyroid			
Heat/Cold Intolerance	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N

BLOOD

Anemia	Y	P	N
Easy bleeding/bruising	Y	P	N
Fatigue	Y	P	N

I hereby certify that I have supplied correct and accurate information to the best of my knowledge.

Name______________________________________ Date_____________________
SIGNATURE

Name______________________________________
PRINTED