Maine Family Natural Health

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12 Priest Hill Road * Vassalboro, Maine
(207) 469-5534

PATIENT HEALTH HISTORY

Patient's Name: _____ _____
First Middle Last

Natural medicine healthcare is possible only when the doctor completely understands the patient's physical, mental, and emotional conditions. The information you provide helps your practitioner understand your needs and how to help you reach your health goals. Please write legibly and answer all questions thoroughly. Feel free to mark anything you may have questions about.

Address: _____

City:_____ State: _____ Zip code: _____

Telephone numbers: home _____ work/cell _____

Social Security #: _____ E-Mail: _____

Birth Date: _____ Age: _____ Gender: _____

Occupation(s): _____ Hours per week: _____

Employer: _____ Employer Address: _____

Marital Status: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced ☐ Widowed

With whom do you live? ☐ Spouse ☐ Partner ☐ Parents ☐ Friends ☐ Children ☐ Alone

Spouse/parent name: _____ Spouse/parent SS#: _____

Spouse/parent phone: _____ Spouse/parent birth date: _____

Spouse/parent address (if different from yours): _____

Emergency Contact: _____ Relationship: _____

Telephone numbers: _____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Maine Family Natural Health to release information necessary to secure payment.

Signature: _____ Date: _____

If someone other than the patient is responsible for payment, please complete the following:

Name of responsible party: _____ Social Security #: _____

Relationship to patient: _____ Phone #: _____

Employer & address: _____

How did you hear about Maine Family Natural Health? _____

When did you last visit a doctor's office, medical clinic, or hospital? Please explain. _____
_____

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, dust)? If yes, please list and explain: _____
_____

Self and Family History

What hospitalizations or surgeries have you had? _____
_____
_____

What diagnostic imaging studies have you had? ☐ Bone Density Scan (DEXA) ☐ Mammogram ☐ X-rays ☐ Electrocardiogram (EKG/ECG) ☐ Electroencephalogram ☐ Ultrasound ☐ CT scan ☐ MRI

Medications and Supplements

Do you use any of the following?

- ☐ Pain relievers (aspirin, ibuprofen)
- ☐ Diet pills, appetite suppressants
- ☐ Cortisone (cream or pills)
- ☐ Thyroid medications
- ☐ Sleeping pills
- ☐ Antacids
- ☐ Laxatives
- ☐ Tranquilizers
- ☐ Antibiotics
- ☐ Recreational (Illegal) Drugs (past or present use of any of the following: marijuana, LSD, cocaine, heroin, MDMA, PCP, methamphetamines, drugs not prescribed to you)

Please list any prescriptions medications, over-the-counter medications, vitamins, or other supplements you are taking:

_____
_____
_____

General

What are your current health concerns? _____
_____

Height: _____ Weight: _____lbs. Weight one year ago: _____lbs.

Maximum weight: _____lbs. When? _____

When during the day or night is your energy the highest? _____ The lowest? _____

Briefly describe your spiritual or religious practices: _____

Briefly describe your hobbies or special interests: _____

Please provide the following information about YOUR FAMILY:

Family History

Does/did anyone in your family have any of the following conditions (please circle)?

Anemia	Diabetes	Hayfever/hives	Liver disease
Arthritis	Epilepsy	Heart disease	Mental illness
Asthma	Gallbladder disease	Heart murmur	Stroke
Cancer (any kind)	Glaucoma	High Blood Pressure	Tuberculosis
Cataracts	Goiter	Kidney disease	

Is your father still living? Yes; his age_____ No; age at time of death _____ Cause of death _____
Is your mother still living? Yes; her age _____ No; age at time of death _____ Cause of death _____

Please provide the following information about YOU:

Childhood Illnesses

Please circle if you had any of the following conditions as a child or adolescent:

Diptheria	Mumps
German measles	Rheumatic fever
Measles	Scarlet fever
Chicken pox	Other _____

Past Immunizations

Please circle any of the following immunizations you have had. If unsure, please write a question mark (?) beside the immunization.

(DPT)	Diptheria	Pertussis	Tetanus
(MMR)	Measles	Mumps	Rubella
Polio	Hepatitis B	Chicken Pox	Other _____

Review of Systems

Please circle. Y = yes, present condition N = no, never had the condition P = problem in the past

Head

Headaches	Y P N	Migraine headaches	Y P N
Head injury	Y P N	Jaw or TMJ problems	Y P N

Eyes

Blurred vision	Y P N	Cataracts	Y P N
Glasses/contacts	Y P N	Eye pain/strain	Y P N
Glaucoma	Y P N	Tearing/dryness	Y P N
Spots in vision	Y P N	Color blindness	Y P N
Double vision	Y P N	Nystagmus/twitching	Y P N

Ears

Ringing	Y P N	Dizziness	Y P N
Earaches	Y P N	Impaired hearing	Y P N

Nose/Sinuses

Stuffiness	Y P N	Loss of smell	Y P N
Sinus problems	Y P N	Hayfever	Y P N
Nose bleeds	Y P N	Frequent colds	Y P N

Mouth/Throat

Hoarseness	Y P N	Gum problems	Y P N
Freq. sore throat	Y P N	Jaw clicking	Y P N
Dental cavities	Y P N	Sore lips/tongue	Y P N

Neck

Lumps	Y P N	Swollen glands	Y P N
Goiter	Y P N	Pain or stiffness	Y P N

Skin

Rashes	Y P N	Psoriasis	Y P N
Eczema, hives	Y P N	Lumps	Y P N
Acne, boils	Y P N	Color changes	Y P N
Itching	Y P N	Loss of hair	Y P N
Night sweats	Y P N	Dryness	Y P N

Musculoskeletal

Joint pain	Y P N	Muscle spasms	Y P N
Weakness	Y P N	Arthritis	Y P N
Broken bones	Y P N	Sciatica	Y P N

What type of exercise do you do? _____ How often do you exercise? _____

Respiratory

Asthma	Y P N	Wheezing	Y P N	
Bronchitis	Y P N	Cough	Y P N	
Spitting up blood	Y P N	Difficulty breathing	Y P N	
Sputum/phlegm	Y P N	Pneumonia	Y P N	
Pain with breathing	Y P N	Pleurisy	Y P N	
Emphysema	Y P N	Tuberculosis	Y P N	
Shortness of breath	Y P N	Use tobacco products	Y P N	How much, how often? _____

Cardiovascular

Angina	Y P N	Chest pain	Y P N
Blood clots	Y P N	Heart murmur	Y P N
Heart disease	Y P N	Rheumatic fever	Y P N
Fainting	Y P N	Ankle swelling	Y P N
Low blood pressure	Y P N	High blood pressure	Y P N
Palpitations	Y P N		

Gastrointestinal

Diarrhea	Y P N	Constipation	Y P N	
Change in thirst/appetite	Y P N	Ulcers	Y P N	
Black stool	Y P N	Coughing up blood	Y P N	
Jaundice/yellow skin	Y P N	Hemorrhoids	Y P N	
Gallbladder disease	Y P N	Heartburn	Y P N	
Abdominal pain	Y P N	Blood in stool	Y P N	
Liver disease	Y P N	Drink alcohol	Y P N	How much, how often?

How many bowel movements per day? _____ _____

Urinary

Incontinence	Y P N	Frequent infections	Y P N
Painful urination	Y P N	Kidney stones	Y P N
Frequency at night	Y P N	Dribbling urine	Y P N

Blood/Vascular

Anemia	Y P N	Cold hands/feet	Y P N
Thrombophlebitis	Y P N	Leg pain	Y P N
Easy bruising	Y P N	Varicose veins	Y P N

Neurological

Fainting	Y P N	Paralysis	Y P N
Numbness/tingling	Y P N	Seizures	Y P N
Loss of memory	Y P N	Muscle weakness	Y P N
Absence of sensation	Y P N if yes, where?_____		

Emotional

Mood swings	Y P N	Nervousness	Y P N
Anxiety	Y P N	Depression	Y P N

Endocrine

Hypothryoid	Y P N	Hyperthyroid	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Cold intolerance	Y P N	Heat intolerance	Y P N

Known endocrine/hormonal disorders: _____

General Reproductive (male and female)

Sexually active	Y P N	Fertility issues	Y P N
Sexual difficulty	Y P N	Discharge or sores	Y P N

Sexually transmitted infections Y P N

Please circle those that apply: Herpes Syphilis Gonorrhea Chlamydia HPV HIV/AIDS Trichomonas Hepatitis (B, C, D, E)

Sexual preference: Heterosexual Homosexual Bisexual

Number of biological children: _____ Number of all children (biological and adopted): _____

Male Reproductive

Hernia	Y P N	Testicular masses	Y P N
Prostate issues	Y P N	Testicular pain	Y P N
Premature ejaculation	Y P N	Difficult urination	Y P N

Female Reproductive

Age of first menses_____ Age of last menses (if menopausal)_____

Length of cycle _____ Duration of menses _____

Date of last GYN exam or pap smear _____ Do you do self breast exams? _____ How often? _____

Painful menses	Y P N	Endometriosis	Y P N
Ovarian cysts	Y P N	Heavy flow	Y P N
Cervical dysplasia	Y P N	Abnormal pap smear	Y P N
Breast tenderness	Y P N	Breast mass/lump	Y P N
Nipple discharge	Y P N	Spotting	Y P N
Irregular cycles	Y P N	Absence of menses	Y P N

Birth control Y P N if yes, what types? _____

PMS symptoms: _____

Menopausal symptoms: _____

Number of pregnancies _____ Number of live births _____

Number of miscarriages _____ Number of abortions _____

Difficulties of pregnancy or labor? _____

Is there anything else you would like to include in your health history? _____

_____

HIPAA Notice of Privacy Practices and Consent: I hereby consent to the use and disclosure of my protected health information by Maine Family Natural Health for the purposes of **treatment, payment, and healthcare operations,** or as otherwise required by law.

- Maine Family Natural Health has posted their Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my protected health information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by Maine Family Natural Health.
- I understand that while Maine Family Natural Health may honor these requests, they are not required by law to do so.
- I am aware that Maine Family Natural Health reserves the right to change the terms of their Notice of Privacy Practices and to make new Notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Maine Family Natural Health will make available a revised Notice of Privacy Practice for my review.

Alternative Method of Communication Request:

As a courtesy, it is Maine Family Natural Health's policy to call your home on the working day prior to your scheduled appointment to remind of your appointment time. We may leave a reminder message on your voice-mail or with a person answering the phone – no personal health information will be disclosed.

☐ I agree with Maine Family Natural Health's standard method of communication.
☐ Please change as follows:
  ☐ Please contact me at the following telephone number: _____
  ☐ I prefer not to receive reminder calls.

Statement of Financial Responsibility: I understand and agree to the following:

- Payment for services rendered is my responsibility as the patient or patient's responsible party.
- I am responsible for paying for all services, including lab tests, rendered at the time of service.
- If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service.

Consent for Treatment:

I understand that my care as a patient at Maine Family Natural Health is directed by Dr. Morgan Titus Rau, a licensed naturopathic doctor. I consent to services rendered and provided to me by Dr. Titus Rau.

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I have fully read and understand the above agreements and authorizations. I hereby certify that I have completed this Patient Health History truthfully and to the best of my knowledge.

_____ _____

Patient (18 years or older) **Date**

_____ _____

Parent, Guardian, Responsible Party **Date**