

Dr. Christine C. White
Black Bear Naturopathic Clinic, PC
2831 Fort Missoula Road Suite 105, Missoula, MT 59804
New Patient Health History

Name _____ Date _____

Preferred Name _____ Gender _____ Pronoun Preference _____

Age _____ Date of Birth _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Telephone—Home _____ Work _____ Cell _____

May we leave medical related information on your voicemail? Yes No

Email Address _____ May we contact you by email? Yes No

Occupation/Former Occupation _____ Full-time Part-time

Employer Name & Address _____

Married Separated Single Divorced Widowed Partnered

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

Emergency Contact _____ Relationship _____

Address _____

Telephone—Home _____ Work _____ Cell _____

How did you hear about us? Family/Friend Missoulian Independent Website Phone Book

If you were referred by someone, let us know who so we can thank them _____

Name of Primary Care provider: _____ Approx Date of Last visit _____

When, where and by whom did you last receive medical care? _____

Primary reason for this visit _____

In your opinion, what are your most important physical, emotional, and/or mental health problems?

1. _____

2. _____

3. _____

4. _____

How do you rate your overall health? Excellent Good Fair Poor

What are you expectations for today's visit? _____

What are your expectations for our work together in general? _____

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Hospitalizations

What hospitalizations or surgeries have you had? When did they occur?

Special Studies

What diagnostic imaging studies have you had? (x-rays, CT scan, mammogram, MRI, bone density, EKG, EEG)

Medications, Supplements, Herbs

List all drugs, vitamins, herbs being taken at present with dosage

Are you allergic to any medications or other substances? Yes No

If yes, please list _____

Childhood Illnesses

Rubella (German 3 day measles) Measles (2 week) Mumps Chickenpox Roseola Whooping Cough

Polio Rheumatic Fever Scarlet Fever Asthma Eczema Frequent Ear Infections

Other? _____

Any difficulties with your birth or your mother's pregnancy with you? _____

Immunizations

Unsure, probably all of them Polio Pertussis Tetanus Diphtheria Measles/Mumps/Rubella

Other? _____

Your Health History

Current	Past	
		Allergies
		Anemia
		Arthritis
		Alcoholism
		Bleeding problem
		Cancer
		Candida
		Colitis
		Drug/Alcohol Use
		Eczema
		Emphysema
		Headache
		Head Injury

Current	Past	
		Heart murmur
		High blood pressure
		Injury--Serious
		Kidney disease
		Liver disease
		Overweight
		Pneumonia
		Polio
		Rheumatoid Arthritis
		Thyroid disorder
		Tuberculosis
		Sexually transmitted infection
		Other

Family History

My mother's health is: Good Fair Poor Deceased

My father's health is: Good Fair Poor Deceased

Has any **Blood Relative** had any of the following?

Yes	No	Unsure		Yes	No	Unsure	
			Anemia				Hay fever
			Arthritis				Heart attack
			Asthma				High blood pressure
			Bleeding disorder				Seizure disorder
			Cancer—Type				
			Diabetes				Sickle cell anemia
			Eczema				Thyroid disease
			Glaucoma				Tuberculosis
			Gout				

Social History

Have you traveled outside the USA? _____When/Where _____

Did you serve in the military? Yes No If yes, where/when _____

Do you have a religious or spiritual practice? _____

Overall stress level: Low Average High

In what areas of your life do you experience stress? Work Family Relationships Social Financial School

Please list the 4 most significant stressful events of your life, including childhood stressors.

1. _____
2. _____
3. _____
4. _____

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Health Habits

Number of alcoholic drinks per week, on average: Non-drinker 0-1 1-5 5-10 10+

If so, what? Beer Wine Distilled_____

Do you use tobacco or have you used it in the past? Yes No If so, how many packs/tins per day _____

Total number of years tobacco use_____Total number of years since you stopped?_____

Circle any of the following that you do on a regular basis: Jog Walk Swim Bicycle Garden Hike Yoga

Breathing exercises Stretching Weight Lifting Martial Arts Hunt Fish Other_____

How do you relax?_____

Primary Hobbies?_____

Sleep Patterns (circle): less than 6 hours 6-8 hours 8+ hours light sound can't fall asleep can't stay asleep

Diet

Number of meals eaten per day? 1 2 3 More than 3

How is your appetite? Good Poor Excessive

Who cooks the food you eat?_____

If you eat out, where do you go?_____

Any diet or food restrictions /special diets you follow?_____

List the foods **excluded** from your diet or the ones you avoid_____

Amount of water you drink daily_____Do you drink soda? What, diet/regular_____

Do you drink coffee/regular/decaf/how much?_____

What about your diet do you believe needs to be changed?_____

Home Environment and Other Environmental Exposures

Circle any of the following that apply to your primary dwelling or life in general

Gas heat Oil heat Wood Stove Electric heat Air Conditioning Electric Blanket TV

Water quality? *Distilled Filtered Spring Well Deionized Ozonated Tap*

Do you have a *New Car* or *New Home*?

Do any of the following bother you? *Sunshine Loud noise Crowds Lack of sunshine Dampness Dryness Cold*

Heat Dust Mold Cat hair Dog hair Exhaust Fluorescent lighting Chemicals Perfumes

Reproductive Health

Male

Are you currently sexually active? Yes No Past, not currently

Type of contraception used? _____ Are you satisfied with your contraception? Yes No

Are you concerned about the possibility of a sexually transmitted infection? Yes No

Are you taking hormones of any kind? Yes No If yes, type and dose _____

Do you have any of the following? Testicular Pain Prostate Pain Hernia Penile Discharge Genital Sores

Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 (0=none)

Sexual function: Great, no complaints Starting to have troubles Erectile dysfunction

Female

Are you currently sexually active? Yes No Past, but not currently

Type of contraception used? _____ Are you satisfied with your contraception? Yes No

Are you concerned about the possibility of a sexually transmitted infection? Yes No

Have you ever used—oral birth control pills Norplant Depo-Provera No to all of these options

Are you currently using—oral birth control pills Norplant Depo-Provera

Are you using hormone replacement therapy? Yes No If yes, type and dose _____

Age when menstrual periods started _____ Did you have a normal puberty? _____

You get your period every _____ days. Regular cycles? Yes No

Your periods last _____ days, on average. Date of your last period _____ Cramping Yes No Severe

Quality and quantity of flow—dark red, bright red, clots, very light, very heavy

Are you post menopausal (no period for 12 consecutive months)? Yes No Maybe

PMS Yes No Impacts my life every month

Approximate date of last PAP _____ Have you ever had an abnormal PAP? Yes No When _____

Do you have any concerns about your ability to conceive? Yes No

Any chance you are pregnant now? Yes No Unsure

Number of pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Any pregnancy complications? Yes No Briefly explain any complications _____

History of vaginal infections: Bacterial Vaginosis (BV) Yeast Chlamydia Gonorrhea Herpes HPV

Sexual desire 0 1 2 3 4 5 6 7 8 9 10 (0=none)

Sexual function: Great, no complaints Starting to have troubles Trouble

Any breast health concerns? _____

Date of last mammogram, if applicable: _____

Medical History: *Please Circle* **O** for Occasionally, **Y** for Yes, **P** for Past condition (not current); Leave the rest blank

General		Mouth/Throat		Arms/Legs	
Weight.....		Frequent sore throat....	O Y P	Deep leg pain.....	O Y P
Weight one year ago....		Sore tongue.....	O Y P	Varicose veins.....	O Y P
Maximum Weight.....		Bleeding gums.....	O Y P	Blood clots/thrombophlebitis	O Y P
When.....		Gum disease.....	O Y P	Nail fungus.....	O Y P
Height.....		Chronic hoarseness.....	O Y P	Restless legs.....	O Y P
Significant fatigue.....	O Y P	Dental cavities.....	O Y P	Pain with walking.....	O Y P
Night sweats.....	O Y P	Root canals.....	O Y P		
History of cancer.....	O Y P	Last dental exam.....		Gastrointestinal	
Recent weight loss.....	O Y P			Belching.....	O Y P
Recent weight gain.....	O Y P	Respiratory/Lungs		Gas.....	O Y P
Fevers.....	O Y P	Chronic cough.....	O Y P	Gall bladder pain/removed	O Y P
Autoimmune illness....	O Y P	Chronic mucus.....	O Y P	Heartburn/Reflux.....	O Y P
Genetic condition.....	O Y P	Coughing blood.....	O Y P	Indigestion.....	O Y P
Skin		Wheezing.....	O Y P	Liver disease/problems.....	O Y P
Recurrent Rashes.....	O Y P	Asthma.....	O Y P	Jaundice.....	O Y P
Eczema.....	O Y P	Bronchitis.....	O Y P	Vomiting.....	O Y P
Hives.....	O Y P	Pneumonia.....	O Y P	Blood in stool.....	O Y P
Chronic Itching.....	O Y P	Pleurisy.....	O Y P	Hemorrhoids.....	O Y P
Lumps.....	O Y P	Emphysema.....	O Y P	Binge eating.....	O Y P
Head/Neck		Difficulty breathing.....	O Y P	Abdominal/stomach cramps....	O Y P
Recurrent headaches..	O Y P	Pain with breathing.....	O Y P	Constipation.....	O Y P
Head Injury.....	O Y P	Short of breath.....	O Y P	Diarrhea.....	O Y P
Swollen glands.....	O Y P			# of bowel movements a day	#
Goiter.....	O Y P	Cardiovascular		Muscles/Bones/Joints	O Y P
Chronic pain/stiffness	O Y P	Heart disease.....	O Y P	Joint pain/stiffness.....	O Y P
Whiplash.....	O Y P	Angina/Chest pain.....	O Y P	Arthritis.....	O Y P
Eyes		Hypertension.....	O Y P	Muscle cramps.....	O Y P
Eye pain.....	O Y P	Murmurs.....	O Y P	Weakness.....	O Y P
Tearing/dryness.....	O Y P	Rheumatic fever.....	O Y P	Frequent injury.....	O Y P
Double vision.....	O Y P	Ankles swelling.....	O Y P	Bone loss/Osteoporosis.....	O Y P
Glaucoma.....	O Y P	Skipped/ irregular beats	O Y P		
Cataracts.....	O Y P	Fainting.....	O Y P	Nervous System	
Corrective lenses.....	O Y P	High Cholesterol.....	O Y P	Seizures.....	O Y P
Ears				Numbness /tingling.....	O Y P
Hearing loss.....	O Y P	Urinary		Memory loss.....	O Y P
Ringing/tinnitus.....	O Y P	Pain with urination.....	O Y P	Balance problems.....	O Y P
Earaches.....	O Y P	Increased frequency.....	O Y P		
Chronic ear infections..	O Y P	Frequency at night.....	O Y P	Endocrine/Hormones	
Nose/Sinuses		Urgency/unable to hold.	O Y P	Hypothyroid.....	O Y P
Frequent colds.....	O Y P	Bladder/Kidney		Hyperthyroid.....	O Y P
Nose bleeds.....	O Y P	infections.....	O Y P	Low blood sugar.....	O Y P
Chronic Stuffiness.....	O Y P	Kidney stones.....	O Y P	Diabetes.....	O Y P
Hay fever.....	O Y P	Circulatory		PCOS.....	O Y P
Sinus infections.....	O Y P	Easy bruising.....	O Y P	Chilly, cold hands and feet.....	O Y P
Sinus surgeries.....	O Y P	Anemia.....	O Y P	Hot and sweaty.....	O Y P
		Cold hands/feet.....	O Y P	Metabolic Syndrome.....	O Y P

Mood		Reproductive-Female		Reproductive-Male	
Panic Attacks.....	O Y P	Endometriosis.....	O Y P	BPH.....	O Y P
ADD/ADHD.....	O Y P	Breast Cancer.....	O Y P	Genital Warts.....	O Y P
Anxiety.....	O Y P	Fibrocystic Breasts.....	O Y P	Lesions.....	O Y P
Anger Issues.....	O Y P	Fibroids.....	O Y P	Erective Dysfunction.....	O Y P
Bi-polar.....	O Y P	Genital Herpes.....	O Y P	Prostatitis.....	O Y P
Irritability.....	O Y P	Vaginal Dryness.....	O Y P	Genital Herpes.....	O Y P
Depression.....	O Y P	Hysterectomy.....	O Y P	Low libido.....	O Y P
Weepy.....	O Y P	Infertility.....	O Y P		
		Pain with intercourse.....	O Y P		
		Breast tenderness.....	O Y P		
		Low libido.....	O Y P		
		Ovarian cyst.....	O Y P		

Health Insurance Information:

Insurance Co. Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

I.D. # _____ Group# _____

Subscriber Name (If other than patient) _____ Date of Birth _____

Relationship to patient _____

Please Initial and Sign:

_____ I authorize Dr. Christine C. White to examine and treat me.

_____ I understand that the treatments and therapies provided or recommended by this clinic may be different from those offered by another licensed health care provider, and that I am at liberty to seek other care as well.

_____ I understand that payment is expected at the time of service.

_____ If I choose to submit billings to my insurance company, I consent to the release of all information the insurance company may request for the filing of insurance claims.

Patient Signature _____ Date _____

Responsible Party, if other than the patient _____ Date _____