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Name \_\_\_\_\_ Date \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Female/Male/FtoM/MtoF (please circle one)  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_ Retired \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
Social Security# \_\_\_\_\_ Education \_\_\_\_\_  
Email \_\_\_\_\_ May we contact you via email? Y N  
Please circle: What is your relationship status?  
Single Significant Partnership Married Separated Divorced Widowed  
Who do you live with? Alone Spouse Partner Relatives Friends Parents

Who should we contact in an emergency? \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone numbers \_\_\_\_\_ or \_\_\_\_\_

### HISTORY QUESTIONNAIRE

Holistic health care and preventive medicine are only possible when the physician has complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. You may mark anything you don't understand with a question mark.

When and where did you last receive medical/health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

What are your most important health concerns? List as many as you can in order of importance:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

What positive attributes can you describe about your health? List as many as you can.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who may I thank for your referral? \_\_\_\_\_

**Family History:** Please check applicable health conditions for each person in your family.

	Father	Mother	Brother	Sisters	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____	_____
Gen Health: G=Good/P=Poor	_____	_____	_____	_____	_____	_____
Cancer (type?)	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Alzheimer's	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness (type?)	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____
Age (at death) & cause	_____	_____	_____	_____	_____	_____

For the following sections, please circle Y=Yes or N=No

**Childhood Illnesses:**

Scarlet fever	Y N	Diphtheria	Y N	Rheumatic Fever	Y N
Mumps	Y N	Measles	Y N	German Measles	Y N
Polio	Y N	Other	_____		

**Hospitalization and Surgery:** What hospitalizations or surgeries have you had and when:

\_\_\_\_\_

**X-rays and Special Studies:** X-rays, CAT scans, or MRI's you have had and when:

\_\_\_\_\_

Electrocardiogram(EKG)	Y N	Electroencephalogram (EEG)	Y N
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**Immunizations:**

Polio	Y N	Pertussis	Y N
Tetanus Shot (not antitoxin)	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Other	_____

**Allergies:** Please list any foods, drugs, or other allergens:

\_\_\_\_\_

**Current Medications: Do you take any of the following?**

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Hormones	Y N	Sleeping pills	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Antidepressants	Y N

**Please list prescription medications, over the counter medications, vitamins and other supplements you are taking:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please circle one:

**Y** = a condition you have now. **P** = a condition you have had in the past. **N** = you've never had.

<b>General:</b>	Current Weight	_____	<b>Resp (cont):</b>	Bronchitis	Y P N
	Weight 1 yr ago	_____		Pleurisy	Y P N
	Maximum weight	_____		Emphysema	Y P N
	When	_____		Wheezing	Y P N
	Height	_____		Asthma	Y P N
	Fatigue	Y P N		Shortness of breath	Y P N
<b>Skin</b>				at night	Y P N
	Rashes	Y P N		lying down	Y P N
	Itching	Y P N		on exertion	Y P N
	Eczema	Y P N		Difficulty breathing	Y P N
	Acne	Y P N		Pain with breathing	Y P N
	Color Changes	Y P N		Pneumocystis	Y P N
	Lumps	Y P N		Tuberculosis	Y P N
	Nights sweats	Y P N	<b>Cardiovascular</b>		
<b>Head</b>				Heart disease	Y P N
	Headaches	Y P N		Chest pain	Y P N
	Head Injury	Y P N		Angina (diagnosed)	Y P N
<b>Eyes</b>				Palpitations, fluttering	Y P N
	Impaired vision	Y P N		High blood pressure	Y P N
	Glasses or contacts	Y P N		Murmurs	Y P N
	Eye pain	Y P N		Rheumatic Fever	Y P N
	Tearing	Y P N		Swelling/Edema	Y P N
	Dryness	Y P N	<b>Gastrointestinal</b>		
	Double vision	Y P N		Bowel movements	
	Glaucoma	Y P N		How often? _____	
	Cataracts	Y P N		Is this a change? _____	
<b>Ears</b>				Nausea	Y P N
	Impaired hearing	Y P N		Vomiting	Y P N
	Ringing	Y P N		Vomiting blood	Y P N
	Earache	Y P N			
	Dizziness	Y P N		Blood in stool	Y P N
<b>Nose and Sinuses</b>				Gallbladder disease	Y P N
	Frequent colds	Y P N		Liver Disease	Y P N
	Nose bleeds	Y P N		Jaundice(yellowskin)	Y P N
	Sinus Congestion	Y P N		Change in thirst	Y P N
	Sinus infections	Y P N		Change in appetite	Y P N
	Hay fever/Allergies	Y P N		Trouble swallowing	Y P N
<b>Mouth and Throat</b>				Belching/passing gas	Y P N
	Frequent sore throat	Y P N		Heartburn	Y P N
	Sore tongue	Y P N		Ulcer	Y P N
	Gum problems	Y P N		Hemorrhoids	Y P N
	Hoarseness	Y P N	<b>Urinary</b>		
<b>Neck</b>				Pain on urination	Y P N
	Lumps	Y P N		Increased frequency	Y P N
	Swollen glands	Y P N		Frequency at night	Y P N
	Goiter (Thyroid)	Y P N		Inability to hold urine	Y P N
	Pain or stiffness	Y P N		Frequent infections	Y P N
<b>Respiratory</b>				Kidney stones	Y P N
	Cough	Y P N			
	Sputum	Y P N			
	Coughing up blood	Y P N			

## Female Reproductive

Date last Menstrual Cycle \_\_\_\_\_  
Average # of bleeding days \_\_\_\_\_  
Days between cycles \_\_\_\_\_  
Bleeding between periods Y P N  
Are cycles regular Y P N  
Pain during intercourse Y P N  
Painful menses Y P N  
Excessive flow Y P N  
Birth control? Y P N  
What type? \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_  
Number of live births \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_  
Number of abortions \_\_\_\_\_  
Difficulty conceiving Y P N  
Menopausal symptoms Y P N  
Are you sexually active? Y P N  
Sexual difficulties Y P N  
Sexually transmitted infections Y P N  
Sexual Orientation:  
Heterosexual \_\_\_\_\_  
Bisexual \_\_\_\_\_  
Homosexual \_\_\_\_\_

**Breasts** Do you do self exam? Y P N  
Lumps Y P N  
Fibrocystic breasts Y P N  
Pain or tenderness Y P N  
Nipple discharge Y P N

## Male Reproductive

Hernias Y P N  
Testicular masses Y P N  
Testicular pain Y P N  
Are you sexually active? Y P N  
Sexual difficulties Y P N  
Prostate Disease Y P N  
Sexually transmitted infection Y P N  
Discharge or sores Y P N  
Sexual Orientation:  
Heterosexual \_\_\_\_\_  
Bisexual \_\_\_\_\_  
Homosexual \_\_\_\_\_

## Musculoskeletal

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

Thrombophlebitis Y P N  
Cold hands/feet Y P N  
Varicose veins Y P N

## Neurologic

Fainting Y P N  
Seizures Y P N  
Paralysis Y P N  
Muscle Weakness Y P N  
Numbness or tingling Y P N  
Loss of memory Y P N

## Emotional

Depression Y P N  
Mood Swings Y P N  
Anxiety Y P N  
Tension Y P N

## Endocrine

Hypothyroid Y P N  
Heat or cold intolerance Y P N  
Excessive thirst Y P N  
Excessive hunger Y P N  
Diabetes Y P N

## Blood

Anemia Y P N  
Easy bleeding or bruising Y P N

## Habits

What are your main interests and hobbies?

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Do you exercise? Y N  
What forms? \_\_\_\_\_

How often? \_\_\_\_\_

Do you eat three meals daily Y N  
Sleep well Y N  
Awake rested Y N  
Average # hours sleep \_\_\_\_\_  
Take vacations Y N  
Enjoy your work Y N  
Spend time outside Y N  
Watch television Y N

Read \_\_\_\_\_  
how many hours a day? Y N

Use tobacco \_\_\_\_\_  
If yes, # cigarettes per day Y P N

Drink alcoholic beverages Y P N  
If yes, average # drinks per week \_\_\_\_\_

Use recreational drug Y P N  
Treated for alcoholism Y P N  
Treated for drug abuse Y P N

Please describe your typical diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snacks: \_\_\_\_\_

Dinner: \_\_\_\_\_

Other: \_\_\_\_\_