Dr. Judith Ziol,
Naturopathic Medical Doctor

New Patient Paperwork

Please complete/bring to initial appointment

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Street Address: _____

City: _____ State:_____ Zip:_____

Home phone: _____Work Phone: _____Cell Phone: _____

Email _____ Preferred method for contact_____

May we add you to our email list? Y N How did you hear about us? _____

_____

Marital Status (circle): Single, Married, Separated, Divorced, With Partner, Widow(er)

Person to call in case of Emergency: _____

Relationship to you: _____

Emergency contact phone number: _____

Other Physicians you see and their specialty: _____

_____

List your health concerns in order of importance to you:

1.

2.

3.

4.

Family history

	Father	Mother	Siblings	Spouse	Children
Age if living	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____
Cancer (type)	_____	_____	_____	_____	_____
High Blood Pressure	Y N	Y N	Y N	Y N	Y N
Heart Attack/stroke	Y N	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N

List All Surgeries and Hospitalizations—including date occurred:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Please Note When and Why You Had Each of The Following:

X-rays: _____

MRI/Cat Scans: _____

Ultrasounds: _____

Accidents: _____

Please List All Sensitivities/Allergies/Reactions

Drugs: _____

Foods: _____

Environment: _____

Circle Yes (Y), Never (N), or Past (P) regarding use of the following:

Antacids: Y N P
Steroids: Y N P
Smoking: Y N P
Packs per day if Yes/Past:_____
Analgesics: Y N P
Laxatives: Y N P

Coffee: Y N P
Cups per day if Yes/Past: _____
Alcohol: Y N P
How often and how much if Yes/Past: _____
Any alcohol addiction: Y N P
Any alcohol treatment: Y N P
Recreational drugs: Y N P
Type: _____
Any drug addiction: Y N P
Any drug treatment: Y N P

List all prescription medicines/dosages and nutritional supplement/herbs taking:

_____

_____

_____

Review Of Systems:

Present Weight:_____ Height: _____

Maximum weight and when: _____ Ideal Weight:_____

REGARDING THE NEXT LONG SECTION: Please Circle
(Y) if you have the problem NOW,
(N) if you've NEVER had the problem,
(P) if you had the problem in the PAST.

Good energy: Y N P
Fatigue: Y N P
If you have fatigue, when is it worse; morning, afternoon, evening? _____

SKIN

Rash: Y N P
Color change: Y N P
Hives: Y N P
Lump: Y N P
Psoriasis/eczema: Y N P
Itchy: Y N P
Dry: Y N P
Warts/moles: Y N P
Cancer: Y N P
Skin cancer type: _____
Skin check by dermatologist: Y N
When/findings: _____

HEAD

Headache: Y N P
Migraine: Y N P
Head injury: Y N P
Hair loss: Y N P
Examination by neurologist: Y N
When/findings: _____

EYES

Dry/Watery: Y N P
Blurry vision: Y N P
Double vision: Y N P
Cataracts: Y N P
Glaucoma: Y N P
Styes: Y N P
Strain: Y N P
Discharge: Y N P
Itchy: Y N P
Dark under eyelid: Y N P
Examination by eye doc: Y N
When/findings: _____

NOSE

Frequent colds: Y N P
Nosebleeds: Y N P
Chronic sinusitis Y N P
Post nasal drip: Y N P
Polyps: Y N P
Seasonal allergies: Y N P
Loss of smell: Y N P

MOUTH/THROAT

Canker sores: Y N P
Cold sores: Y N P
Sore throat: Y N P
Gum disease: Y N P
Dentures: Y N P
Cavities: Y N P
Loss of taste: Y N P
Hoarseness: Y N P
Last dental exam: _____

NECK

Stiffness: Y N P
Swollen glands: Y N P
Full movement: Y N P
Tension: Y N P

RESPIRATORY

Cough: Y N P
TB: Y N P
Shortness of breath with exertion: Y N P
Bronchitis: Y N P
Shortness of breath sitting: Y N P
Pneumonia: Y N P
Shortness of breath lying down: Y N P
Asthma: Y N P
Wheezing: Y N P
Painful breathing: Y N P

CARDIOVASCULAR

High blood pressure: Y N P
Rheumatic fever: Y N P
Low blood pressure: Y N P
Murmurs: Y N P
Arrhythmias: Y N P
Palpitations: Y N P
Edema: Y N P
Chest pain: Y N P
Examination by cardiologist: Y N When/findings: _____

GASTROINTESTINAL

Heartburn: Y N P
Bowel movement frequency: _____
Indigestion: Y N P
Recent change in BM: Y N P
Bloating: Y N P
Diarrhea or constipation: Y N P
Nausea: Y N P
Hemorrhoids: Y N P
Vomiting: Y N P
Gall bladder disease: Y N P
Change in Appetite: Y N P
Liver disease: Y N P
Pancreatitis: Y N P
Ulcer: Y N P
Colonoscopy: Y N When/findings: _____

URINARY TRACT

Incontinence: Y N P
Pain with urination: Y N P
Frequent infections: Y N P
Kidney stones: Y N P
Urgency: Y N P
Discharge/blood: Y N P

MALE GENITALIA

Testicular pain/swelling: Y N P
Sexually active: Y N P
Hernia: Y N P
Sexually transmitted disease: Y N P
Discharge: Y N P
Prostate disease/symptoms: Y N P
Impotency: Y N P
Sexual orientation: Hetero Homo Bi

FEMALE GENETALIA

Age periods began: _____ How often periods occur: _____
How long periods last: _____ Menopausal since what age: _____
Periods: times pregnant: _____
Heavy bleeding: Y N P How many births: _____
Cramping: Y N P Miscarriages: _____
Pain: Y N P Abortions: _____
PMS: Y N P Sexually active: Y N P
Food cravings: Y N P Healthy libido: Y N P
Last pap smear: _____ Pain with intercourse: Y N P
Last menstrual cycle _____ Dry vagina: Y N P
Any abnormal paps: Y N P Sexual orientation: Hetero Homo Bi
Any birth control (please list types and ages used): _____
Sexually transmitted diseases: Y N P Diagnosis: _____
Mammography: Y N P Findings: _____
Dexa scan: Y N P Results: _____
Use of hormones replacement: Y N P Type: _____

MUSCULOSKELETAL

Weakness: Y N P Arthritis: Y N P
Stiffness: Y N P Leg cramps: Y N P
Tremors: Y N P Pain: Y N P

NERVOUS

Paralysis: Y N P Sciatica: Y N P
Tingling/numbness: Y N P Carpal tunnel syndrome: Y N P
Seizures: Y N P Fainting: Y N P

MENTAL/EMOTIONAL

Depression: Y N P Anger/irritability: Y N P
Suicidal: Y N P High-strung/tense: Y N P
Anxiety: Y N P Fear/Panic: Y N P

EXERCISE

How often: _____
What type(s): _____
For how long: _____
Hobbies:
_____
_____

SLEEP

How long per night: _____
If you wake up frequently, what is the reason: _____
Wake refreshed: Y N P
Grind Teeth: Y N P
Snore: Y N P

Current Occupation: _____

TOXIN EXPOSURE

Did you grow up near any refinery, or polluted area, or in home with leaded paint? Y N

If so, what sort of pollution were you exposed to: _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials: _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing: _____

Are you particularly sensitive to perfumes, gasoline, or other vapors: _____

Do you use pesticides, herbicides, or other chemicals around your home: _____

SOCIAL LIFE

Enjoy job: Y N P

Active Spiritual practice: Y N P

History of sexual, mental/emotional, physical abuse: Y N P

How committed are you towards making valuable changes: Little Moderately Very

I look forward to partnering with you to help you achieve your healthcare goals!

In health,
Dr. Judith Ziol