Mona Bhalla, ND, LLC
Knott Street Health Center
443 NE Knott St.
Portland, OR 97212
503-282-5350

Patient's name _____ _____ _____
Please print *Last* *Middle* *First*

Natural medicine healthcare is possible only when the physician completely understands the patient's physical, mental, and emotional condition. The information you provide helps the doctor understand your needs and how to help you reach your health goals. Please answer each question completely. Print all information and mark anything about which you have questions.

Address _____
Street or POB
_____
City, state, zip
Phone _____
Home *Cell*
_____
Work (with extension)
Email _____
SSN _____

Date of birth _____ Age ___ ☐ Female ☐ Male

Emergency contact _____
Name
_____
Address
_____
Phone
_____
Relationship

Occupation _____

How many children do you have? _____

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other _____

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

Who can I thank for the referral? _____

_____

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

_____

_____

_____

_____

_____

What are your major health concerns?

_____

_____

_____

_____

_____

_____

Signature _____
Responsible party if patient is a minor

Please print name _____ Date _____

HOSPITALIZATION AND SURGERY

What hospitalization or surgeries have you had?

_____

_____

_____

_____

_____

X-RAYS AND SPECIAL STUDIES

What diagnostic imaging studies have you had?

☐ Electrocardiogram ☐ Electroencephalogram

☐ Xrays ☐ Mammogram

☐ CT scan ☐ MRI

☐ Bone density scan

☐ Other _____

MEDICATIONS OR SUPPLEMENTS

List medications/supplements you currently take.

_____

_____

_____

_____

_____

Please check (✓) the box for any of the following you currently take:

☐ Pain relievers (aspirin/Tylenol)

☐ Diet pills/appetite suppressants

☐ Cortisone (cream or pills)

☐ Thyroid medication

☐ Sleeping pills

☐ Antacids (Rolaids/Tums)

☐ Laxatives

☐ Tranquilizers

ALLERGIES

Do you have allergies to food, drugs, or other allergens in your environment (ie - cats, mold, dust)? If yes, please explain. ☐ No ☐ Yes

_____

_____

_____

_____

IMMUNIZATIONS

What immunizations have you had? Please place a "?" on the line if you do not know.

☐ ___ Diphtheria ☐ ___ Measles/mumps/rubella

☐ ___ Polio ☐ ___ Pertussis

☐ ___ Tetanus shot (not antitoxin)

☐ ___ Other _____

_____

CHILDHOOD ILLNESSES

Have you had the following illnesses?	☐ Yes	☐ No
Scarlet fever	☐	☐
Diphtheria	☐	☐
Rheumatic fever	☐	☐
Rheumatic fever	☐	☐
Mumps	☐	☐
Measles	☐	☐
German measles	☐	☐

Other _____

SELF AND FAMILY HISTORY

Father

Health ☐ Good ☐ Poor

Age (at death) _____

Cause of death _____

_____

Mother

Health ☐ Good ☐ Poor

Age (at death) _____

Cause of death _____

_____

SELF AND FAMILY HISTORY (continued)

Please check (✓) the box for any of the following that you or family members have experienced.

Cancer	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Diabetes	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Heart disease	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
High blood pressure	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Stroke	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Epilepsy	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Mental illness	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Asthma	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Hayfever, hives	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Anemia	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Kidney disease	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Liver disease	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Gallbladder disease	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Ulcer	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Tuberculosis	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Goiter	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Arthritis	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Heart murmur	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Cataracts	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____
Glaucoma	☐ self	☐ father	☐ mother	☐ sister	☐ brother	☐ children	☐ _____

REVIEW OF SYSTEMS: *Please circle the response that applies:*

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

GENERAL

Weight _____ Weight 1 year ago _____
Maximum weight _____
When _____ Height _____

Fatigue	Y	P	N

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

EYES

Impaired vision	Y	P	N
Glasses or contacts	Y	P	N
Eye pain	Y	P	N
Tearing or 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 AND 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 AND THROAT

Frequent sore throat	Y	P	N
Sore tongue	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental cavities	Y	P	N

NECK

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

RESPIRATORY

Cough	Y	P	N
Sputum	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Pleurisy	Y	P	N
Emphysema	Y	P	N
Difficulty breathing	Y	P	N
Pain on 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 blood pressure	Y	P	N
Murmurs	Y	P	N
Rheumatic fever	Y	P	N
Chest pain	Y	P	N
Swelling in ankles	Y	P	N
Palpitations, fluttering	Y	P	N

REVIEW OF SYSTEMS (continued): *Please circle the response that applies:*

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

GASTROENTESTINAL

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 Y P N
Vomiting blood Y P N
Bowel movements
How often? _____
Is this a change? _____
Blood in stool Y P N
Belching or passing gas Y P N
Jaundice (yellow skin) Y P N
Liver disease Y P N
Hemorrhoids 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 of days? _____
Length in cycle? _____
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? ☐ Yes ☐ No
What type? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Difficulty conceiving ☐ Yes ☐ No
Menopausal symptoms Y P N

Are you sexually active? ☐ Yes ☐ No
Sexual difficulties Y P N
Venereal disease Y P N
Sexual preference ☐ Heterosexual
☐ Bisexual
☐ Homosexual
Do you self-exam? Y P N
Lumps Y P N
Pain or tenderness Y P N
Nipple discharge Y P N

MALE REPRODUCTIVE

Hernia Y P N
Testicular masses Y P N
Testicular pain Y P N
Are you sexually active? ☐ Yes ☐ No
Sexual difficulties Y P N
Venereal disease Y P N
Discharge or sores Y P N
Sexual preference ☐ Heterosexual
☐ Bisexual
☐ Homosexual

MUSCULOSKELETAL

Joint pain or stiffness Y P N
Arthritis Y P N
Broken bones Y P N
Muscle spasms or 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

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 or nervousness 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

BLOOD

Anemia Y P N
Easy bleeding or bruising Y P N

HABITS

What are our main interests and hobbies?

_____

_____

_____

_____

_____

Do you exercise? ☐ Yes ☐ No
How many days per week? _____
What type of exercise do you do?

_____

_____

_____

_____

Eat three meals daily? ☐ Yes ☐ No
Awaken rested? ☐ Yes ☐ No
Sleep well? ☐ Yes ☐ No
Avg 7–8 hours' sleep? ☐ Yes ☐ No
Enjoy your work? ☐ Yes ☐ No
Spend time outside? ☐ Yes ☐ No
Take vacations? ☐ Yes ☐ No
Watch television? ☐ Yes ☐ No
How many hours per day? _____
Read? ☐ Yes ☐ No
How many hours per day? _____
Use recreational drugs? ☐ Yes ☐ No
Use tobacco? ☐ Yes ☐ No
Drink alcohol? ☐ Yes ☐ No
Treated for alcoholism? ☐ Yes ☐ No
Treated for drug dependence? ☐ Yes ☐ No

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

Name _____

Date _____