



**NATUROPATHIC
MEDICINE**
of Southern Arizona

**Laser
Therapeutics**

2469 N Country Club Rd • Tucson, AZ 85716
Phone: 520-577-6888 • Fax: 520-325-0898
www.DoctorAsTeacher.com

CONFIDENTIAL PATIENT INFORMATION

Please print or write legibly.

Today's Date: _____

Full Name _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Phone: Home(_____) _____ Cell (_____) _____

Fax (_____) _____

Email _____

May we subscribe you to our clinic's email newsletter? Yes No

Whom may we thank for referring you to us? _____

Gender: Male Female

Age _____ Birth date (Month/Day/Year) _____ / _____ / _____

Height (feet) _____ Weight (pounds) _____

Marital Status: Married Single Widowed Divorced

Pregnant? Yes No # of children _____

Could you possibly be pregnant now? Yes No

Circle one or more: FT Employment PT Employment FT Student PT Student

Occupation _____ Employer _____

Work Phone (_____) _____

Person to be notified in case of an emergency:

Name _____

Address _____

Telephone _____ Relationship _____

| Reason for appointment & related health issues/problems? | Date Began? | Had Previously? | Injury Related? |
|--|-------------|-----------------|-----------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Name of your Primary Care Physician (PCP) _____

* Please note that Dr. Smith chooses to not be a Primary Care Physician.

PCP Telephone (_____) _____ Date of last visit _____

Date of last check up or physical _____

Diagnosis of current health issue(s) if available _____

Are you willing to change your habits in order to improve your health? Yes Maybe No

Are you currently utilizing any other therapies or practitioners for these issues? Yes No

If yes, what practitioner(s)/therapy(ies)? _____

MEDICAL HISTORY

Serious illnesses (type, duration, year): _____

Surgeries (type, year performed): _____

Known Allergies, Hypersensitivities or Intolerances: _____

Current Supplements: _____

Current Medications (include over the counter): _____

CONSTITUTIONAL

Hours of sleep per night: _____

Do you exercise regularly? Yes No Type of exercise: _____

Are you currently or were you previously on a restrictive diet? Yes No

Do you smoke tobacco? Yes No Now? _____ Past? _____ Packs per week _____

Do you drink alcohol? Yes No Drinks per week: _____

History of treatment for addiction? Yes No Tobacco/ Alcohol/ Drugs/ Other

Do you have a history of extensive travel to foreign countries? Yes No

If yes, which countries and for how long? _____

FAMILY HISTORY

Please indicate, to the best of your knowledge, whether any of your biological family members have any of the following conditions:

Mother (M) Father (F) Brother (B) Sister (S) Grandparent (G) Your Children (C)

| | M | F | B | S | G | C | | M | F | B | S | G | C |
|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Tendency | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous/Mental | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

REVIEW OF BODY SYSTEMS

Check any of the boxes below that apply to

1. symptoms that you have experienced in the past 3 months

2. diagnoses you have received during your lifetime

GENERAL

- Recent weight loss
Amount? _____
Time period? _____
- Recent weight gain
Amount? _____
Time period? _____
- Inability to lose/gain weight (circle one)
- Eating Disorder
- Body Odor
- Appetite Change
- Tiredness/Weakness
- Sudden energy drop
Time of day? _____
- Fever
- Sweating at night
- Sweating when tired
- Trouble falling asleep
- Trouble staying asleep
- Wake up not rested
- Strong thirst
- Cravings

HEMATOLOGIC

(BLOOD-RELATED)

- Blood type _____
- Anemia
- Bleeding Tendency
- Coagulation disorder
- Bruise easily
- Cuts heal slowly
- Blood clots
- Stroke

HEAD, EYE, EAR, NOSE, THROAT

- Disturbances of vision
- Red or itchy eyes
- Glaucoma
- Macular degeneration
- Eyeglasses/contacts
- Loss of hearing
- Ringing in ears
- Pain in ears
- Disturbances of speech
- Trouble swallowing
- Sore or dry throat

- Lip or mouth sores
- Nosebleeds
- Nose or sinus problems
- TMJ pain/problems
- Loss of taste or smell
- Headache(s)
Type(s) _____

MOUTH

- Halitosis (bad breath)
- Bleeding gums
- Mercury/amalgam (dark) fillings
- Problems with teeth or dentures
- Implants
- Other _____

RESPIRATORY (LUNGS)

- Wet Cough
- Dry cough
- Whooping Cough

- Excessive Sneezing
- Asthma
- Nasal or sinus problems
- Poor sense of smell
- Chest Pain or tightness
- Shortness of Breath
- Congestion
- Wheezing Rib Pain
- Tuberculosis
- Emphysema
- Bronchitis
- Pneumonia
- Pleurisy

**GASTRO-
INTESTINAL
SYSTEM**

- Constipation
- Loose stool or Diarrhea
- Diarrhea & Constipation
- Gripping/cramping
- Red Blood in stool
- Food visible in stool
- Very Dark Stool
- Light colored stool
- Frothy/bubbly stool
- Hard stool
- Symptoms with fatty foods
- Rectal pain
- Itching or burning
- Celiac Sprue
- Crohn's Disease
- IBS/IBD
- Diverticulosis/-itis
- Hemorrhoids
- Ulcerative colitis
- Parasite infection
- Nausea
- Vomiting
- Heartburn/Acid Reflux/GERD
- Fatigue after eating
- Constantly hungry
- Lack of appetite

- Lactose intolerant
- Hiatal hernia
- Ulcers
- Indigestion
- Candida or other GI fungus
- Abdominal pain
- Gas/flatulence
- Belching
- Bloating
- Jaundice (yellowing of skin and eyes)
- Hepatitis
- Cirrhosis
- Gallbladder problems
- # of bowel movements:
per day _____
per week _____
- Other _____

**GENITO-URINARY
SYSTEM**

- Lower Abdominal Pain
- Kidney/Renal problem
- Renal insufficiency
- Water retention
- Abdominal Hernia
- Sexually Transmitted Disease
- Infertility
- Difficulty with urination
- Pain with urination
- Interstitial cystitis
- Inability to hold urine (incontinence)
- Blood in urine
- Dark urine
- Urethral discharge
- Bladder infection

FEMALE ISSUES

- Painful periods
- Menstrual cramps
- PMS
- Irregular periods

- Excessive bleeding
- Abnormal lack of menses
- Endometriosis
- Hot flashes
- Vaginal Dryness
- Miscarriage/Abortion
- Menopause: peri- or post- (please circle)
- Sexual difficulties
- Painful breasts
- Lumps in breasts
- Birth Control Pills
- Uterine: fibroids/cysts/tumors
- Pregnancy # _____
- Children # _____

MALE ISSUES

- Prostate problems
- Sexual difficulties
- Testicular pain/swelling

**MUSCULO-
SKELETAL SYSTEM**

- Arthritis
Type(s): _____
- Osteopenia/osteomalacia/Osteoporosis
- Gout
- Shingles
- Fibromyalgia/Chronic Fatigue Syndrome
- Joint pain /swelling
- Scoliosis
- Flat feet
- Pins & needles sensation
- Numbness or lack of sensation
- Accident, injury, or trauma—Which body part(s) was involved?

**CARDIOVASCULAR
(HEART) SYSTEM**

- Palpitations (sudden, episodic, strong heart beats)
- High blood pressure
- Low blood pressure
- Dizziness upon standing/rising
- High cholesterol
- Chest pain or angina
- Bruise easily
- Edema
- History of heart murmur(s)
- Swollen ankles or feet
- Cold hands or feet
- Heart attack # _____
- Stroke/CVA/TIA # _____
- Heart disease
- Slow heart rate
- Fast heart rate
- Poor circulation
- Blood clots
- Poor blood clotting/coagulation
- Sweaty hands or feet
- Anemia
- Pacemaker
- Vascular (blood vessel) disease
- Phlebitis
- Aneurysm
- Varicose Veins

**CENTRAL
NERVOUS SYSTEM**

- Fainting
- Tinnitus (ear ringing)
- Convulsions/Epilepsy
- Multiple Sclerosis
- Weakness or paralysis
- Loss of feeling or function in body part(s)
- Balance difficulties
- Dizziness
- Vertigo
- Light-headedness
- Neuritis (nerve inflammation)
- Parkinson's Disease
- Bell's Palsy

**ENDOCRINE
(HORMONE)
SYSTEM**

- Diabetes (Type I or Type II, please circle)
- Syndrome X, Metabolic Syndrome
- Hypoglycemia (low blood sugar)
- Thyroid problems
- Hormone therapy

EMOTIONAL

- Worry
- Moodiness
- Anxiety
- Irritability

- Nervousness
- Depression
- Grief
- Problems in relationships

**DERMATOLOGIC
(SKIN) AND HAIR**

- Rash/Itching
- Oozing skin sores
- Psoriasis/Eczema
- Rosacea
- Loss of hair
- Toenail fungus
- Skin fungal infection

IMMUNE SYSTEM

- Seasonal allergies
- Chemical sensitivity
- Cancer
- Benign tumor
- Epstein-Barr Virus (EBV)
- HIV / AIDS
- Lupus
- Rheumatoid Arthritis
- Thrush
- Herpes
- Polio
- Mumps
- Rubella
- Chicken Pox
- Malaria
- Measles