

# Natural Medicine of NH, LLC

Lisa Klasman, ND

*Patient Note: This is a confidential record of your medical history. It will not be released except with your authorization. Please complete this questionnaire as thoroughly as possible. Mark anything you do not understand with a question mark. Thank you.*

Date \_\_\_\_\_  Male  Female SSN \_\_\_\_\_

Name \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ DOB \_\_\_\_\_

Age \_\_\_\_\_

Phone \_\_\_\_\_  It's ok to leave message about my care

Email \_\_\_\_\_

Occupation \_\_\_\_\_

**Employment Status:** Full-time Part-time Student Retired Unemployed  
**Please circle:** Married Divorced Single Widowed Significant Partnership  
**Live with:** Spouse Partner Relatives Friends Alone Pets

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about Dr. Klasman:

Referral/Friend \_\_\_\_\_  
Yellow pages Lecture Walk or Drive-by Article Internet

What are your main health concerns?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## Financial Agreement

I claim full financial responsibility for services rendered by Dr. Lisa Klasman and understand payment is required at the time of service. *This SCHEDULED APPOINTMENT time is reserved especially for you. Provided 24-hour notice is given, there will be no charge for missed appointments.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Are you receiving health care from another practitioner? Y N  
If yes, where and from whom?

**Your Opinions About Your Health**

How does your condition affect you?

What do you think is happening; why do you think you have this condition?

What do you feel needs to happen for you to get better?

How much change are you willing to make at this time for improving your health?

circle one: MINIMAL SOME COMPLETE

**Allergies**

To any drugs?

To any foods?

To any environmental pollens/grasses?

Other?

**Surgeries:** List the type and year of any surgeries:

**Hospitalizations:** List any other hospitalizations and the reason:

List all the **medications** that you are currently taking, including dosages:



**Personal Medical History:**

Please circle any of the following conditions/symptoms you have had,  
**Yes**-I have this now; **Never**-I've never had it; **Past**-I've had it in the past but not now.

**Head**

Headaches	Y	N	P	Migraines	Y	N	P
Lightheadedness	Y	N	P	Dizziness	Y	N	P
Bell's Palsy	Y	N	P	Head injury or trauma	Y	N	P
Concussion	Y	N	P	Loss of balance	Y	N	P
Jaw/TMJ problems	Y	N	P	Other? _____			

**Eyes**

Spots in eyes	Y	N	P	Impaired vision	Y	N	P
Blurriness	Y	N	P	Color blindness	Y	N	P
Double vision	Y	N	P	Eye pain	Y	N	P
Swollen eyes	Y	N	P	Eyestrain	Y	N	P
Cataracts	Y	N	P	Glasses/contacts	Y	N	P
Tearing or dryness	Y	N	P	Glaucoma	Y	N	P
Night blindness	Y	N	P	Circles under eyes	Y	N	P
Other _____							

**Ears**

Impaired hearing	Y	N	P	Deafness	Y	N	P
Earaches	Y	N	P	Itching of ears	Y	N	P
Ringing in ears	Y	N	P	Excessive ear wax	Y	N	P
Frequent ear infections	Y	N	P	Other? _____			

**Nose & Sinuses**

Frequent colds	Y	N	P	Stuffiness	Y	N	P
Post nasal drips	Y	N	P	Loss of Smell	Y	N	P
Nose bleeds	Y	N	P	Sinus Problems	Y	N	P
Hayfever	Y	N	P	Allergies	Y	N	P
Polyps	Y	N	P	Other? _____			

**Mouth & Throat**

Frequent sore throat	Y	N	P	Sores in mouth	Y	N	P
Hoarseness	Y	N	P	Difficulty swallowing	Y	N	P
Loss of taste	Y	N	P	Teeth grinding	Y	N	P
Sore lips	Y	N	P	Enlarged lymph nodes	Y	N	P
Sore tongue	Y	N	P	Gum problems	Y	N	P
Dental problems	Y	N	P	Difficulty speaking	Y	N	P
Dental cavities	Y	N	P	Jaw clicks	Y	N	P
Copious saliva	Y	N	P	Dry mouth	Y	N	P
Other? _____							

**Respiratory**

Coughing	Y	N	P	Spitting up blood	Y	N	P
Wheezing	Y	N	P	Difficulty breathing	Y	N	P
Pain with breathing	Y	N	P	Shortness of breath	Y	N	P
Sputum	Y	N	P	Bronchitis	Y	N	P
Pleurisy	Y	N	P	Emphysema	Y	N	P
Pneumonia	Y	N	P	Asthma	Y	N	P
Positive TB Test	Y	N	P	Other? _____			

**Cardiovascular**

Heart disease	Y	N	P	High/Low blood pressure	Y	N	P
Blood Clots	Y	N	P	Phlebitis	Y	N	P
Rheumatic Fever	Y	N	P	Swelling in ankles	Y	N	P
Bleeding/clotting disorder	Y	N	P	High cholesterol	Y	N	P
Atherosclerosis	Y	N	P	Angina	Y	N	P
Heart murmurs	Y	N	P	Fainting	Y	N	P
Palpitations	Y	N	P	Heart Flutters	Y	N	P
Chest Pain	Y	N	P	Stroke	Y	N	P
Heart attack	Y	N	P	High cholesterol	Y	N	P
Atherosclerosis	Y	N	P	Other? _____			

**Circulation**

Cold hands/feet	Y	N	P	Deep leg pain	Y	N	P
Easy bleeding/bruising	Y	N	P	Varicose veins	Y	N	P
Thrombophlebitis	Y	N	P	Other? _____			

**Gastrointestinal**

Trouble swallowing	Y	N	P	Jaundice	Y	N	P
Nausea	Y	N	P	Vomiting blood	Y	N	P
Blood in stool	Y	N	P	Abdominal pain/cramps	Y	N	P
Belching or passing gas	Y	N	P	Gallbladder disease	Y	N	P
Ulcers	Y	N	P	Liver disease	Y	N	P
Hepatitis	Y	N	P	Heartburn	Y	N	P
Acid Reflux	Y	N	P	Change in appetite	Y	N	P
Diarrhea	Y	N	P	Constipation	Y	N	P
Bloating	Y	N	P	Stomach pain	Y	N	P
Black Stools	Y	N	P	Diverticulitis/losis	Y	N	P
Crohn's disease	Y	N	P	Irritable Bowel Syndrome	Y	N	P
Hemorrhoids	Y	N	P	Change in thirst	Y	N	P
Colitis	Y	N	P	Hiatal Hernia	Y	N	P
Vomiting	Y	N	P	Other? _____			

Frequency of bowel movements (number per day) \_\_\_\_\_

Quality of stools (small and hard, loose, etc.) \_\_\_\_\_

**Urinary**

Pain during urination	Y	N	P	Frequency at night	Y	N	P
Bladder infections	Y	N	P	Unable to urinate	Y	N	P
Increased frequency	Y	N	P	Unable to hold urine	Y	N	P
Kidney stones	Y	N	P	Blood in urine	Y	N	P
Other? _____							

Approximate number of times you urinate per day \_\_\_\_\_

Wake up at night to urinate: Y N Pain or other symptoms during urination. Y N

**Skin**

Rashes	Y	N	P	Hives	Y	N	P
Acne, boils	Y	N	P	Moles	Y	N	P
Lumps	Y	N	P	Ulceration	Y	N	P
Shingles	Y	N	P	Eczema	Y	N	P
Psoriasis	Y	N	P	Itching	Y	N	P
Dryness	Y	N	P	Perpetual hair loss	Y	N	P
Night sweats	Y	N	P	Sores	Y	N	P
Infections	Y	N	P	Change in hair/nails	Y	N	P
Other?	_____						

**Neck**

Pain or stiffness	Y	N	P	Swollen Glands	Y	N	P
Pinched nerve	Y	N	P	Lumps	Y	N	P
Herniated disk	Y	N	P	Other?	_____		

**Musculoskeletal**

Joint pain or stiffness	Y	N	P	Muscle spasms	Y	N	P
Muscle weakness	Y	N	P	Arthritis	Y	N	P
Bursitis	Y	N	P	Osteoporosis	Y	N	P
Osteopenia	Y	N	P	Broken Bones	Y	N	P
Back Pain	Y	N	P	Herniated disk	Y	N	P
Back surgery	Y	N	P	Other?	_____		

**Neurological**

Seizures	Y	N	P	Muscle weakness	Y	N	P
Loss of memory	Y	N	P	Vertigo	Y	N	P
Dizziness	Y	N	P	Trembling hands/feet	Y	N	P
Mood swings	Y	N	P	Epilepsy	Y	N	P
Paralysis	Y	N	P	Numbness or tingling	Y	N	P
Loss of balance	Y	N	P	Lightheaded	Y	N	P
Poor concentration	Y	N	P	Slurred speech	Y	N	P
Neuralgia	Y	N	P	Loss of coordination	Y	N	P
Easily stressed	Y	N	P	Other?	_____		

**Mental / Emotional**

Excess Stress	Y	N	P	Anxiety	Y	N	P
Panic Attacks	Y	N	P	Depression	Y	N	P
Mood swings	Y	N	P	Memory loss	Y	N	P
Suicidal thoughts	Y	N	P	Treated for emotions	Y	N	P
Nervousness	Y	N	P	Seasonal depression	Y	N	P
Other?	_____						

**Endocrine**

Hypothyroid	Y	N	P	Hyperthyroid	Y	N	P
Hypoglycemia	Y	N	P	Excessive thirst	Y	N	P

Unexplained weight loss	Y	N	P	Fatigue	Y	N	P
Hormonal problems	Y	N	P	Heat or cold intolerance	Y	N	P
Diabetes	Y	N	P	Excessive hunger	Y	N	P
Easy weight gain	Y	N	P	Pituitary disorder	Y	N	P
Adrenal problem	Y	N	P	Other? _____			

**Immune**

Slow wound healing	Y	N	P	Chronic fatigue syndrome	Y	N	P
Chronic swollen glands	Y	N	P	Reaction to vaccinations	Y	N	P
Chronic infections	Y	N	P	Cancer	Y	N	P
Other? _____							

**Infectious Illnesses**

Scarlet Fever	Y	N	P	Diphtheria	Y	N	P
Rheumatic Fever	Y	N	P	Chicken Pox	Y	N	P
German Measles	Y	N	P	Mumps	Y	N	P
Measles	Y	N	P	Polio	Y	N	P
Meningitis	Y	N	P	Epstein-Barr	Y	N	P
Other? _____							

**Male Reproductive System History:**

**Male Genitourinary**

Urinary Frequency	Y	N	P	Urging without passing urine	Y	N	P
Waking during night to urinate	Y	N	P	Pain/burning	Y	N	P
Trouble starting urine	Y	N	P	Cloudy urine	Y	N	P
Red-tinged/blood urine	Y	N	P	Foul-smelling urine	Y	N	P
Prostate Cancer	Y	N	P	BPH	Y	N	P
Testicular cancer	Y	N	P	Penile cancer	Y	N	P
Pain or sores on penis	Y	N	P	Discharge from penis	Y	N	P
Hernias	Y	N	P	Testicular pain	Y	N	P
Testicular swelling	Y	N	P	Lumps on testicles	Y	N	P
Scrotum or penis	Y	N	P				
Inability to achieve or maintain an erection	Y	N	P				
Premature ejaculation	Y	N	P				
Surgery of prostate, genitals, hernia, vasectomy	Y	N	P				
Other? _____							

**Sexual History**

Are you currently sexually active? **YES NO** With men, women or both? \_\_\_\_\_

Do you have multiple partners? **YES NO**

Do you experience pain or discomfort during sex? **YES NO**

Do you use condoms or other birth control methods? **YES NO** \_\_\_\_\_

**Your Childhood History:** To the best of your memory, please provide the following information about YOUR childhood

Did your parents note any adverse reactions to vaccinations or illnesses around the time you received them?

During each of the following age periods, what illnesses did you have?

- birth to 2 years

- 2 years to 5 years

- 5 years to puberty

- puberty through roughly age 20

**Family Medical History:**

	<b>Mother</b>	<b>Father</b>	<b>Brothers</b>		<b>Sisters</b>		<b>Children</b>	
Age (if living)								
Cancer								
Diabetes								
Heart Trouble								
High Blood Pressure								
Stroke								
Epilepsy								
Mental disorders								
Asthma								
Allergies								
Other conditions								
Age of Death								
Cause of Death								

**Form complete.**

**Welcome to Natural Medicine of NH!**