



Vashon Natural Medicine

Homegrown Healthcare Since 1998

Dr. Kelly Wright
Naturopathic Physician

Dr. Michelle Obertacz, L.Ac.
Naturopathic Physician

New Patient Information

* = **required info** *Date of Birth ____ / ____ / ____ Age ____ Female Male SS# _____

*Last Name _____ *First Name _____ M.I. _____

*Mailing Address _____

*City _____ State _____ Zip _____ *Home Phone _____

Work Phone _____ Cell Phone _____

***May we leave a message on your home phone? Y N May we call you at work? Y N**

If no, how can we contact you? _____

*Emergency Contact _____ *Phone _____ * Relationship _____

What are you expectations of Naturopathic Medicine? _____

Health History

Primary health concern _____ Secondary concern _____

Name and location of last physician _____ Date of last physical _____

Most recent lab work date and type: _____

Dates for the following: Most recent cholesterol check: _____ Colonoscopy? Date: _____

Your health as a child Good Fair Poor Childhood illnesses _____

Hospitalizations: Year Reason Year Reason

Surgeries: Year Reason Year Reason

Women

Date of last Pap/Annual Exam _____ First date of *last* menstrual period _____

Date of last Mammogram _____ Results ____ Normal ____ Abnormal

Men

If over age 40 date of last prostate exam: _____ Date of last PSA test: _____

Current Medications

Prescription _____

Non prescription _____

18913 Vashon Hwy SW Vashon, WA 98070

Phone: 206.463.4778 • Fax: 206.463.4791 • Pager: 206.995.5582

Allergic Reactions

Drugs _____ Foods _____ Environmental _____

List any chemicals, metals, dusts or fumes to which you have been or are *repeatedly exposed*

Lifestyle

Do you have a special diet? _____

Exercise: Type _____ Number of Times per week _____ For how long? _____

Occupation: _____ Hours per week _____ Stress level: Average Medium High

Stress reducing Activities: _____

Sleep: Average hours per night _____ Quality of sleep _____ How often do you wake at night? _____

Caffeine use: (coffee, tea, latte, etc.) _____ Frequency per day or week _____

Substance Abuse History: Drug Type _____

Frequency _____ Number of Years _____ Years stopped _____

Alcohol Use: Frequency _____ Type _____ Alcohol treatment in the past? Y N

Cigarette smoking: Y N Number of packs per day _____ # of years smoking _____

Years stopped _____ (plus #'s 1-2) Other nicotine use (cigar, pipe, etc.) _____

Have you been tested for HIV?: Y N Most recent test date _____ Results: Positive Negative

Immunization history: Tetanus _____ Hepatitis A _____ Hepatitis B _____

Military History: Years served from _____ to _____ Location of duty _____

Are you sexually active _____ Do you use contraception _____ if yes, what type _____

Number of pregnancies _____ Number of children _____ Names of children and their ages: _____

Current living situation: ___ Alone ___ w/Partner ___ w/Spouse ___ w/Family ___ Other

Family History

	Self	Father	Mother	Brother	Sister	Grandparent	Other relative
Alzheimer's	_____	_____	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____	_____
Cancer (type?)	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____	_____
Hay fever/Hives	_____	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____	_____
High Blood pressure	_____	_____	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____	_____