Bay Area Natural Medicine Center

Health History Form

Name:_____ Age: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: Home ( ) _____ Work ( ) _____E-mail:_____

Emergency Contact: _____ Relationship: _____ Day Phone: ( ) _____

Occupation: _____ How did you hear about us? _____

Name of Health Insurance:_____HMO/PPO/EPO/Medicare?other:_____

Preferred contact number: _____ Preferred Shipping Address_____

Chief Complaint: In this section please list in order of importance your health concerns.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Current Medication List: In this section please list all pharmaceutical medication(s) that you are currently taking along with dosage and frequency

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Are you allergic to any medications? Yes _ No _____

If "Yes", please list: _____

What happens when you have an allergy attack to medication? _____

Hospitalizations: Include reason, year and duration: _____

_____

Current Supplement List: In this section please include all homeopathics, herbs, vitamins, minerals you are currently taking with dosage.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Social History:

Are you currently: Married _____ Divorced _____ Single _____ Long-Term Relationship _____Widowed _____

Number of children and ages? _____

Date of last physical exam: _____ **Men**: Date of last prostate exam: _____

Have you traveled outside the US in the past year? Yes____ No ____If yes, where? _____

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Health Habits:

	Yes	No	If "yes", how long or how much per week?
Do you exercise?			
Do you smoke tobacco? Now or in the past.			
Do you drink alcohol?			
Do you use recreational drugs?			
Do you drink coffee, soda or black tea?			
Do you drink "diet" sodas or eat "diet" foods?			
Are you familiar with "safe sex" practices?			
Do you follow any dietary modifications?			If yes, please describe:

Food or Environmental Allergies: List any known allergens here:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Women Only: Gynecology and Pregnancy

Date of last gynecology exam: _____ Any abnormalities?_____
Please specify the number of: Births _____ Miscarriages _____ Abortions _____
Age at first period: _____ Age at Menopause: _____ Menopausal symptoms: _____
Cycle (circle one) Regular / Irregular Duration of flow (days): _____ Time between cycles: _____
Flow (circle one): Excessive / Moderate / Scanty

PMS (circle one): Yes / No

Symptoms: _____

Cramps (circle one): Severe / Mild / None

Date of last period: _____ Method of birth control: _____

- ❑ Breast lumps
- ❑ Breast tenderness
- ❑ History of genital warts
- ❑ Mother or sister with breast cancer
- ❑ Nipple discharge
- ❑ Pain during intercourse
- ❑ Pain during orgasm
- ❑ Abnormal Vaginal discharge
- ❑ Vaginal dryness
- ❑ Vaginal itching
- ❑ Vulvar itching
- ❑ Water retention
- ❑ Pass clots with periods
- ❑ Past or current use of IUD
- ❑ Perform self breast examination regularly
- ❑ Spotting between periods
- ❑ History of abnormal pap?
- ❑ Infertility problems

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Past Medical History: In this section, please check the appropriate box that applies to you.

Illness	Now	Past	Never	Illness	Now	Past	Never
Allergies				Gout			
ADD/ADHD				Headaches or Migraine			
Alcoholism				Heart Murmur			
Altered sense: (e.g. taste, smell)				Hemorrhoids			
Anemia				High Blood Pressure			
Anxiety/Depression				HIV/AIDS			
Arthritis				Hyperthyroid			
Asthma				Hypothyroid			
Bleeding Difficulties				Injury (Serious)			
Blood in Stools				Kidney Disease			
Blurred Vision				Liver Disease/Jaundice			
Cancer				Low blood sugar			
Candida (yeast) infection				Numbness/Tingling			
Chemical Sensitivities				Obesity			
Chronic Fatigue				Other (specify)			
Colitis				Ovarian Cysts			
Diabetes				Pneumonia			
Dizziness/Vertigo				Post Traumatic Stress D/O			
Eczema				Recreational Drug use			
Emphysema				Rheumatoid Arthritis			
Fainting				Schizophrenia			
Fibromyalgia				Seizure/epilepsy			
Genital Herpes				Stroke			
GI Ulcers				Syphilis			
Glaucoma				Tuberculosis			

Family History: Complete for those applicable and check box if yes for appropriate relation.

	Mother	Father	Brother(s)	Sister(s)	Grandparents	Child
Age if living						
Age at death						
Cause of death						
Alcoholism						
Alzheimer's Disease						
Anemia						
Asthma Allergy Hives						
Autoimmune Disease						
Cancer						
Depression/Suicide						
Diabetes						
Epilepsy						
Gastrointestinal Dz						
Glaucoma						
Heart Disease						
High Blood Pressure						
HIV/AIDS						
Mental Illness						
Obesity						
Parkinson's Disease						
Syphilis						
Tuberculosis						

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Review of Systems: In this section, please check the appropriate box.

	Yes, Currently	Yes, in Past	Never
General:			
Do you usually feel tired or worn out?			
Have you recently been more thirsty than normal?			
Has there been any unusual weight gain or loss recently?			
Do you perspire a lot?			
Do you prefer warm?			
Do you prefer cold?			
Skin/Hair/Nails			
Have you noticed any changes in the color of your skin?			
Have you noticed any skin rashes or itching?			
Have you noticed any unusually dry skin?			
Have you noticed any growth on your skin that bothers you?			
Have you noticed any sores or wounds that do not heal?			
Have you noticed any change in color or size or warts?			
Do you have dry skin or brittle nails?			
Eyes:			
Have you had any pain in your eyes?			
Have you had any blurry vision?			
Are you nearsighted or farsighted (circle one)			
Have you noticed any change in your vision?			
Do you often have itchy eyes?			
Have you noticed any redness or burning in your eyes?			
Do you see halos around lights?			
Ears, Nose, Throat:			
Do you have any difficulty hearing?			
Do you have any ringing or buzzing in your ears?			
Do you have earaches or discharge from your ears?			
Do you have a lot of nasal stuffiness or sinusitis?			
Do you have drainage down the back of your throat?			
Ears, Nose and Throat (cont.)			
Do you experience frequent or severe nosebleeds?			
Do you have any lumps in your throat?			
Do you experience sore tongue or mouth?			
Do you have bleeding or easily infected gums?			
Do have excessive saliva?			
Do you have bad breath?			
Respiratory			
Do you have frequent chest colds?			
Do you have a constant or bothersome cough?			
Do you cough up blood?			
Do you have sputum or phlegm between colds?			
Do you have any difficulty breathing?			
Have you noticed any wheezing or whistling?			

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Cardiovascular	Yes, Now	Yes, In Past	Never
Do you have pain, tightness or pressure in front or back of your chest?			
If yes, is it when walking fast, working hard or when excited?			
Have you ever had an abnormal EKG?			
Do you have swelling of your feet or ankles?			
Do you have cramps in the calf muscles when you walk?			
Do you ever awaken at night with difficulty breathing?			
Do you need to sleep on more than one pillow?			
Does your heart ever beat fast or irregularly?			
Do your fingers or toes ever get cold, become numb or blue?			
Gastrointestinal			
Have you recently had any change in your eating habits?			
Are there any foods that give you upset or pain?			
Have you recently experienced nausea or vomiting?			
Do you have excessive gas? (burping or passing gas?)			
Have you ever vomited blood?			
Do you have a lot of indigestion, heartburn or reflux?			
Have you recently experienced any trouble swallowing?			
Do you experience constipation?			
Do you experience diarrhea?			
Do you have a poor appetite or are easily satiated?			
Have you ever had blood in your stools?			
Do you have hemorrhoids?			
Do you take laxatives regularly?			
Do you feel bloated after meals?			
Do you experience abdominal pain or cramping?			
Genitourinary			
Do you have any burning or pain on urination?			
Do you have any change in frequency of urination?			
Have you experienced urinary incontinence?			
Do you get up at night to urinate?			
Do you have a problem dribbling urine?			
Have you ever passed blood in your urine?			
Do you have frequent bladder or kidney infections?			
Men, do you have prostate trouble?			
Men, have you ever experienced erectile dysfunction?			
Musculoskeletal			
Do you experience regular backpain?			
Do you have pain in your legs or feet?			
Have you ever been diagnosed with scoliosis?			
Do you have joint pain or stiffness?			
Do you have trouble walking or using your hip or knee joints?			
Do you experience regular pain in your body? (specify)			

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Central Nervous System	Yes, Now	Yes, In Past	Never
Do you have frequent or severe headaches?			
Do you have dizzy spells, faintness or lightheadedness?			
Do you sometimes lose track of what happens around you for a short time?			
Do you sometimes lose the ability to speak for a few seconds?			
Have you fainted, blacked out or lost consciousness?			
Do you consider yourself a nervous person?			
Do you have trouble remembering recent events?			
Have you ever had convulsions or fits?			
Do you experience insomnia?			
Have you been highly emotional lately?			
Psychological/mental status			
Do you experience depression?			
Do you experience anxiety or panic attacks?			
Have you ever been hospitalized for a psychological condition?			
Have you ever had any suicidal attempts?			
Do you have suicidal thoughts?			
Do you experience excessive restlessness?			
Do you experience mental confusion?			
Are you critical of yourself?			
Are you critical of others?			
Do you experience mood swings?			
Do you experience loneliness?			
Have you ever been diagnosed with a psychological condition?			
Environmental Exposure			
Have you ever worked around known toxic chemicals?			
Have you ever been exposed to chemical solvents?			
Do you use oil paints?			
Do you have mercury amalgam fillings?			
Have you ever been excessively exposed to toxic fumes? Eg gasoline, exhaust fumes, burning of toxic synthetic materials etc.			
Do you have any know exposure to any heavy metals?			
Are you a gardener?			

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New Patient Office Policy

Welcome to Bay Area Natural Medicine Center. We look forward to helping you achieve your health goals. We aim to provide the best naturopathic health care available. Please feel free to let us know how we can better serve your needs. All new patients will need to have an intake form filed out prior to your first visit with your naturopathic doctor. Please fill out the forms as accurately as possible and provide copies of relevant laboratory tests (if possible).

Bay Area Natural Medicine Center is a cash-based practice and payment is expected at time of service. Payment methods include check (preferable), Visa, MasterCard, or cash. If you have an insurance policy that will reimburse you for naturopathic medicine visits we will provide you with a superbill with appropriate diagnostic and billing codes that you can submit to the insurance company for reimbursement of your visit. We suggest that you make a copy of the superbill prior to submission because of consistent insurance clerical error. Our office will not interact with insurance companies on your behalf.

Cancellation Policy

We have a 48 hour cancellation/reschedule policy. If you do not call our offices 48 hours prior to your scheduled appointment, you will be charged for the full office visit fee.

We require a credit card number for our records to schedule your first appointment. Your credit card will not be charged unless you do not provide adequate cancellation notice and will be kept on file for missed appointments or appointments with inadequate cancellation notice.

By signing below, I agree that I have read and understood the policy. I guarantee payment of all charges incurred a s a patient of Bay Area Natural Medicine Center.

Signed:_____ Date:_____

Printed Name:_____Date:_____

Parent of Guardian (minor):_____Date:_____

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Notice of Privacy Practices

To our patients: This notice describes how health information about you , as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:
Use the disclosure of your health information in certain special circumstances

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

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Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Bay Area Natural Medicine Center, 1419 Burlingame Avenue Suite P1, Burlingame, CA, 94010.

   Note: We must respond to this request within 30 days

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Bay Area Natural Medicine Center, 1419 Burlingame Avenue Suite P1, Burlingame, CA, 94010.

Note: We must respond within 60 days. The Privacy Officer or the patient's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager at Bay Area Natural Medicine Center. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact us at Bay Area Natural Medicine Center.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Bay Area Natural Medicine Center has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Dr. Melody Wong
650-375-8869

I also understand that I am entitled to receive updates upon request If Bay Area Natural Medicine Center amends or changes its Notice of Privacy Practices in a material way.

_____ _____

Signature Relation to Patient, if signed by someone other than patient

_____

Date

THIS SECTION IS TO BE COMPLETED BY BAY AREA NATURAL MEDICINE CENTER IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (specify): _____

_____ _____

Name and title of employee Date

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