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avalonnaturalmedicine.com

1. **Please enter your information.**

First Name: ______ Middle Initials: ______ Last Name: ______

Preferred name (if different from legal name): ______ Date of Birth: ______

Street Address: ______ Apt./Unit #: ______ City: ______ State: ______ Zip Code: ______

Mobile Phone: ______ Home Phone: ______ Work Phone: ______

Email: ______

Preferred contact method:
- ○ Mobile Phone ○ Home Phone
- ○ Work Phone ○ Email

Social Security Number: ______

2. Insurance Company: ______ Policy #: ______ Group #: ______

Name of Insured: ______ Relation to Insured: ______

3. **Person to call in case of Emergency:**

Name: ______ Relationship: ______ Phone number: ______

4. **Are you currently receiving healthcare elsewhere?**

- ○ Yes
- ○ No

5. **Please list your health care team:**

______

6. **Last blood work and where it was drawn:**

______

7. **List your single most important health concern:**

____

8. **How committed are you to making changes?**

____

Social history

9. Sex assigned at birth: ____________________ Gender: ____________________

Sexual Orientation: ____________________ Marital Status: ____________________

10. **Do you have any children?**

- ○ Yes
- ○ No

11. **If yes, please list their ages:**

	Name(s)	Age(s)
1		
2		
3		

12. Pets? ____________________ Spiritual practice? ☐ Yes ☐ No

Symptoms:

13. Toxin Exposure

	Y	N
Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?	Y	N
Have you ever had health problems following home refurbishing?	Y	N
Do you experience symptoms with fragrances?	Y	N
Do you use pesticides, herbicides, other chemicals around your home?	Y	N

14. General

	Y	N
Fever	Y	N
Chills	Y	N
Fatigue	Y	N
Weight change	Y	N
Poor appetite	Y	N
Night sweats	Y	N

15. Eyes

Date of last eye exam:

____

Glasses/Contacts
☐ Yes ☐ No

Poor night vision
☐ Yes ☐ No

Sensitivity to light
☐ Yes ☐ No

Dark under eyelid
☐ Yes ☐ No

Blurry vision
☐ Yes ☐ No

Dry
☐ Yes ☐ No

Itchy
☐ Yes ☐ No

Watery
☐ Yes ☐ No

Discharge
☐ Yes ☐ No

Strain
☐ Yes ☐ No

Styes
☐ Yes ☐ No

Cataracts
☐ Yes ☐ No

Glaucoma
☐ Yes ☐ No

16. Head

	Y	N
Headache	Y	N
Migraine	Y	N
Head injury	Y	N
Dandruff	Y	N
Dry hair	Y	N
Oily hair	Y	N

17. Ear

	Y	N
Hearing changes	Y	N
Sensitivity to sound	Y	N
Ringing	Y	N
Earache	Y	N
Infections	Y	N
Discharge	Y	N

18. Nose

	Y	N
Seasonal allergies	Y	N
Post nasal drip	Y	N
Congestion	Y	N
Polyps	Y	N
Nosebleeds	Y	N
Frequent colds	Y	N

19. Mouth/Throat

Date of last dental exam:

____

Canker sores
☐ Yes ☐ No

Cold sores
☐ Yes ☐ No

Cavities
☐ Yes ☐ No

Dentures
☐ Yes ☐ No

Gum disease
☐ Yes ☐ No

Loss of taste
☐ Yes ☐ No

Sore throat
☐ Yes ☐ No

Difficulty swallowing
☐ Yes ☐ No

Hoarseness
☐ Yes ☐ No

20. Respiratory

	Y	N
Painful breathing	Y	N
Shortness of breath	Y	N
Cough	Y	N
Asthma	Y	N
Lung infections	Y	N

21. Cardiovascular

	Y	N
Chest pain	Y	N
Arrythmias	Y	N
Palpitations	Y	N
Murmurs	Y	N
Edema	Y	N
High blood pressure	Y	N
Low blood pressure	Y	N

22. Bowel movement frequency:

____

Date of last colonoscopy:

____

23. Gastrointestinal

	Y	N
Constipation	Y	N
Diarrhea	Y	N
Heartburn	Y	N
Indigestion	Y	N
Bloating	Y	N
Nausea	Y	N
Vomiting	Y	N
Ulcer	Y	N
Pancreatitis	Y	N
Liver disease	Y	N
Hemorrhoids	Y	N
Gallbladder disease	Y	N

24. Pelvic Organs/Urinary

	Y	N
Sexually active	Y	N
Contraception	Y	N
Poor Libido	Y	N
STI/STD	Y	N
Painful intercourse	Y	N
Discharge	Y	N
Urgency	Y	N
Pain with urination	Y	N
Blood in urine	Y	N
Kidney stones	Y	N
Frequent urinary infection	Y	N
Hernia	Y	N
Testicular bumps/swelling	Y	N
Testicular pain	Y	N
Self-testicular exam	Y	N
Erection problems	Y	N
Abnormal PSA	Y	N
Enlarged Prostate	Y	N
Prostate cancer	Y	N

25. Color of urine:

____

26. Gynecology

Age periods began ______________________________

Frequency of menses ______________________________

Length of menses ______________________________

1st day of last menses ______________________________

Date of last mammogram (if applicable) ______________________________

Age when you entered menopause (if applicable) ______________________________

How old was your mother when she entered menopause? ______________________________

Number of pregnancies ______________________________

Number of births ______________________________

Last pap date ______________________________

Was your last pap abnormal?
☐ Y ☐ N

27.

	Y	N
Self-breast exams	Y	N
Breast implants	Y	N
Infertillity	Y	N
Use of hormones	Y	N
Vaginal dryness	Y	N
Vaginitis	Y	N
PMS symptoms	Y	N
Heavy menstrual bleeding	Y	N
Severe menstrual cramping	Y	N

28. **Musculoskeletal:**

	Y	N
Back/Neck pain	Y	N
Weakness	Y	N
Morning stiffness	Y	N
Joint pain	Y	N
Joint swelling	Y	N
Arthritis	Y	N
Muscle pain	Y	N
Muscle cramps	Y	N
Tremors	Y	N
Fractures	Y	N
Joint fusions	Y	N

29. Nervous

	Y	N
Burning/tingling	Y	N
Loss of sensation	Y	N
Seizures	Y	N
Fainting	Y	N
Falling	Y	N
Paralysis	Y	N
Vertigo/Dizzines	Y	N
Difficulty speaking	Y	N

30. Skin

	Y	N
Rash	Y	N
Hives	Y	N
Psoriasis	Y	N
Eczema	Y	N
Dry	Y	N
Itchy	Y	N
Stretch marks	Y	N
Color change	Y	N
Warts	Y	N
Moles		N
Lump	Y	N
Cancer	Y	N
Excess sweat	Y	N
White spots on nails	Y	N
Sensitive to cheap metal, shirt tags, or rough textured fabrics?	Y	N

31. Endocrine

	Y	N
Hair loss	Y	N
Cold intolerance	Y	N
Excess hunger	Y	N
Excess thirst	Y	N
Dizzy when standing up	Y	N
Excess urination	Y	N

32. Describe your:

Focus/Concentration:

Memory/Recall:

Comprehension: