# Patient Profile

green lake natural medicine
5413 Meridian Ave. N. Suite A, Seattle, WA 98103
Tel (206) 550-7539 • Fax (206) 462-4320

Patient name: _____ Date of Birth: _____/_____/_____

Preferred name: _____ Gender/preferred pronoun: _____

***A note to our patients:*** *Please complete this questionnaire as thoroughly as possible in order to aid Dr. Milkis in giving you the most effective visit and care. This is a confidential record of your medical treatment and will not be released, except if you have provided us with written authorization. Thank you for your help.*

What goals do you have for your visit today?

_____

_____

Who is your primary care provider?

_____

Location/Clinic: _____ Phone: (_____)_____

Please list other providers/specialists involved in your care and their locations/phone numbers:

_____

_____

Do you have a cancer diagnosis? If so, what is it:

_____

Who is your Oncologist?

_____

Location/Clinic: _____ Phone: (_____)_____

When was your last physical? _____When did you last have bloodwork? _____

Please indicate the type of care you are seeking (please circle):

Primary management of my health  Ongoing management of my health  Adjunctive care for my health

One time advice for my health  I don't know at this time

Have you ever consulted a Naturopathic physician, Acupuncturist, or other complementary provider before? Yes/No

If yes, which? _____

In general, would you say your health today is: (please circle one)

Excellent  Very good  Good  Fair  Poor

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## Social History

Do you consume alcohol? Yes/No If yes, how many drinks per week and what? _____

Do you use cannabis? Yes/No If yes, for medicinal, recreational use or both? _____

Other drug usage? Yes/No Past/Present What? _____

Current or past tobacco use: Amount/packs per day: _____ How long: _____

If past use, quit date: _____

Are you in a relationship? Yes/No Male/Female Partner How long: _____

Do you have children? Yes/No

If yes, what are their ages and genders?

_____

Do you exercise regularly? Yes/No

If yes, please describe your exercise and frequency:

_____

How is your sleep? Please describe any issues:

_____

How do you rate your stress? Low/Medium/High/Extreme

What are your major stressors?

_____

What do you do to cope with your stress?

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**MEDICAL HISTORY**

Description of any pertinent medical history (self or family):

_____

_____

Birth History: Vaginal delivery/C-Section Were you: Breast fed/Formula fed

Please list ALL surgeries or hospital stays you have had and their approximate date/year:

| Type of surgery/reason for hospitalization: | Date: |
|---|---|
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |

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**ALLERGIES**

Do you have any **medication allergies** or any **allergic reactions** to anything else? Yes/No

If yes, please explain:

_____

_____

Do you have an **EpiPen** for severe allergic reactions? Yes/No/Not applicable

If you have one, what is its expiration date? _____

**MEDICATIONS and SUPPLEMENTS**

Please list **ALL medications and supplements you are taking** (including oral, topical, anything else; prescription, over-the-counter, vitamins, minerals, herbs, etc.; please include brand names if known)

| **Name of medication/supplement** | **Strength** (100 mg, etc.) | **How many/how often?** |
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**Personal and Family Medical History**

Please check boxes to indicate if you or any family member has ever had the following conditions. If condition doesn't apply, leave blank.

| Condition | Self | Mother | Father | Siblings | MGM | MGF | PGM | PGF |
|---|---|---|---|---|---|---|---|---|
| Allergies | | | | | | | | |
| Anemia | | | | | | | | |
| Anxiety | | | | | | | | |
| Arthritis | | | | | | | | |
| Asthma | | | | | | | | |
| Alzheimer's/Dementia | | | | | | | | |
| Blood Transfusion | | | | | | | | |
| Cancer | | | | | | | | |
| Cataracts/Glaucoma | | | | | | | | |
| Clotting disorder | | | | | | | | |
| COPD/Emphysema | | | | | | | | |
| Depression | | | | | | | | |
| Diabetes | | | | | | | | |
| GERD/Reflux | | | | | | | | |
| Heart Attack | | | | | | | | |
| Heart Disease | | | | | | | | |
| Heart Murmur | | | | | | | | |
| High Cholesterol | | | | | | | | |
| Hypertension | | | | | | | | |
| Irritable Bowel Syndrome | | | | | | | | |
| Crohn's/Celiac/Ulcerative Colitis | | | | | | | | |
| Kidney Disease | | | | | | | | |
| Meningitis | | | | | | | | |
| Nerve/Muscle Disease | | | | | | | | |
| Osteoporosis | | | | | | | | |
| Seizures | | | | | | | | |
| Stroke | | | | | | | | |
| Substance Abuse | | | | | | | | |
| Thyroid Disease | | | | | | | | |
| Other (please specify) | | | | | | | | |

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## Signatures

_____ _____

Patient/Guardian Name (please print) Date of Birth

_____ _____

Patient/Guardian Signature Date

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