

Crohn's Wholistic Medical Care  
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**List any Prescribed Drugs, Over-the-Counter Drugs, Vitamins and Inhalers that you are taking**

Name of the Drug (s)	Strength	Frequency Taken

**Allergies to medications**

Name of Medication(s)	Reaction:
Name of Medication(s)	Reaction:
Name of Medication(s)	Reaction:

**HEALTH HABITS AND PERSONAL SAFETY**

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	<input type="checkbox"/> Occasional vigorous exercise (i.e. work or recreation less than 4X a week for 30 minutes or less).
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4X a week or more for 30 minutes)

<b>Diet</b>	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	# Of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	Number of cups/cans per day?			
<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, what kind?			
	How many drinks per week?			
<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew	<input type="checkbox"/> Pipe	<input type="checkbox"/> Cigars
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
<b>Drugs</b>	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Personal Safety</b>	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	What is your Marital Status?	Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/>		

### FAMILY HEALTH HISTORY

AGE (IF DECEASED cause OF DEATH)	SIGNIFICANT HEALTH PROBLEMS(IF DECEASED CAUSE OF DEATH)	SIGNIFICANT HEALTH PROBLEMS
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<b>Father :</b> <b>Age:</b>	<b>Number of Children: (If not living cause of death)</b> <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Living Y or N _____ <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Living Y or N _____ <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Living Y or N _____ <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Living Y or N _____
<b>Living:</b>	
<b>Cause of Death:</b>	
<b>Number of Pregnancies: _____</b>	

<b>Mother:</b> <b>Age:</b>	<b>Siblings :</b> How Many Males:	
<b>Living:</b>		How Many Females:
<b>Cause of Death:</b>		How Many Living:

**Check if your blood relatives had any of the following:**

Cause of Death	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease. Strokes	
	High Blood Pressure	
	Kidney Disease	
Respiratory Disease	Yes                      No	Tuberculosis    Yes                      No

### PAST MEDICAL HISTORY

Have you ever had the following? (Circle Yes or No)

Measles	Yes	No	Anemia	Yes	No	Back trouble	Yes	No
Mumps	Yes	No	Bladder Infections	Yes	No	High Blood Pressure	Yes	No
Chickenpox	Yes	No	Epilepsy	Yes	No	Low Blood Pressure	Yes	No
Whooping Cough	Yes	No	Migraine Headaches	Yes	No	Hemorrhoids	Yes	No
Scarlet Fever	Yes	No	Tuberculosis	Yes	No	Date of last chest x-ray	Yes	No
Diphtheria	Yes	No	Diabetes	Yes	No	Asthma	Yes	No
Smallpox	Yes	No	Polio	Yes	No	Hives or Eczema	Yes	No
Pneumonia	Yes	No	Cancer	Yes	No	AIDS or HIV+	Yes	No
Rheumatic Fever	Yes	No	Glaucoma	Yes	No	Infectious Mono	Yes	No
Heart Disease	Yes	No	Hernia	Yes	No	Bronchitis	Yes	No
Arthritis	Yes	No	Blood/Plasma Transfusion	Yes	No	Mitral Valve Prolapse Stroke	Yes	No
Venereal Disease	Yes	No	Hepatitis	Yes	No	Hepatitis	Yes	No
Ulcer	Yes	No	Kidney Disease	Yes	No	Thyroid Disease	Yes	No
Bleeding Tendency	Yes	No	Other (explain)	Yes	No	Other (explain)	Yes	No

### REVIEW OF SYMPTOMS

**Check if you now have, or have ever had, any symptoms in the following areas to a significant degree and briefly explain.**

**Constitutional Symptoms**

**Endocrine**

**Psychiatric**

Good general health lately	Yes	No	Glandular / Hormone Problem	Yes	No	Memory Loss or Confusion	Yes	No
Recent weight change	Yes	No	Excessive Thirst or Urination	Yes	No	Nervousness	Yes	No
Fever	Yes	No	Heat or Cold Intolerance	Yes	No	Depression	Yes	No
Fatigue	Yes	No	Skin Becoming Dryer	Yes	No	Insomnia	Yes	No

<b>Eyes</b>	<b>Genitourinary</b>			<b>Hematologic/Immunologic/Lymphatic</b>				
Eye disease or injury	Yes	No	Frequent Urination	Yes	No	Slow to Heal after Cuts	Yes	No
Wear glasses/contact lenses	Yes	No	Burning or Painful Urination	Yes	No	Bleeding or Bruising Tendency	Yes	No
Blurred or double vision	Yes	No	Blood in Urine	Yes	No	Anemia	Yes	No
<b>Ears/Nose/Mouth/Throat</b>			Change in force of strain when urinating	Yes	No	Phlebitis	Yes	No
Hearing loss or ringing	Yes	No	Incontinence or Dribbling	Yes	No	Past Transfusions	Yes	No
Earaches or drainage	Yes	No	Kidney Stones	Yes	No	Enlarged Glands	Yes	No
Chronic sinus problem or rhinitis (colds)	Yes	No	<b>Sexual Difficulty</b>	Yes	No	<b>Allergic/Immunologic</b>		

Nose bleeds	Yes	No	Male – Testicle Pain	Yes	No	<b>History of skin reaction or other adverse reaction to:</b>		
Mouth sores	Yes	No	Female – Pain with Periods	Yes	No	Penicillin or other antibiotics	Yes	No
Bleeding gums	Yes	No	Female – Irregular Periods	Yes	No	Morphine, Demerol, or other narcotics	Yes	No
Bad breath or bad taste	Y	No	Female – Vaginal Discharge	Yes	No	Novocain or other anesthetics	Yes	No
Sore throat or voice change	Yes	No	Female number of Pregnancies	Yes	No	Aspirin or other pain remedies	Yes	No
Swollen glands in neck	Yes	No	Female number of Miscarriages	Yes	No	Tetanus antitoxin or other serums	Yes	No

<b>Cardiovascular</b>		Female – Date of Last Pap Smear		____/____/____		Iodine, Merthiolate or other antiseptics		Yes	No
Heart trouble	Yes	No	<b>Musculoskeletal</b>	Other drugs/medications:					
Palpitation	Yes	No	Joint Stiffness or Swelling	Yes	No	<b>Environmental Allergies:</b>			
Shortness of breath w/walking or lying flat	Yes	No	Weakness of Muscles or Joints	Yes	No	Please List Allergens:			
Swelling of feet, ankles or hands	Yes	No	Muscle Pain or Cramps	Yes	No	<b>Known Food Allergies:</b>			
<b>Respiratory (Please Circle)</b>			Back Pain	Yes	No	Please List Foods:			
Chronic or frequent coughs	Cold Extremities		<b>Neurological</b>						
Spitting up blood	Difficulty in Walking		Frequent or recurring headaches /Migraines	Yes	No				
Shortness of breath	Apnea		Light headed or dizzy	Yes	No				
Wheezing	Rash or itching		Convulsions or seizures	Yes	No				
<b>Gastrointestinal (Please Circle)</b>			Change in skin color	Yes	No	Numbness or tingling Sensations:			
Loss of appetite			Change in hair or nails	Yes	No	Tremors	Yes	No	
Change in bowel movements			Varicose veins	Yes	No	Paralysis	Yes	No	
Nausea or vomiting			<b>Breast Changes</b>			Head Injury	Yes	No	
			Breast pain	Yes	No				
Frequent diarrhea			Breast lump	Yes	No				
Painful bowel movements or constipation			Breast discharge	Yes	No				
Rectal bleeding or blood in stool									
Abdominal pain									

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need. (Please Sign and Date)

Signature of:

Patient \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Doctor \_\_\_\_\_ Date \_\_\_\_\_