

**Heidi Peterson, ND**



**4444 SW Corbett Ave, Portland, OR 97201 • 503-224-2590 • 503-224-2592 (fax)**

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

What brings you in the office today? \_\_\_\_\_

\_\_\_\_\_

What expectations do you have from this visit to our clinic? \_\_\_\_\_

\_\_\_\_\_

What are your top health concerns in order of importance?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_

List any medications, over the counter drugs, vitamins or other supplements that you are taking:. Feel free to use additional page. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any allergies to drugs, food, or chemicals: \_\_\_\_\_

\_\_\_\_\_

List any medical problems that you have had in the past. Have you ever been hospitalized or had surgery? If so when and what for? \_\_\_\_\_

\_\_\_\_\_

**Family Medical History:**

Please note the diseases that each of the following members of your family has or had.  
If they are deceased please note the age at which they died and the cause of their death.

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Paternal Grandmother: \_\_\_\_\_

Paternal Grandfather: \_\_\_\_\_

Maternal Grandmother: \_\_\_\_\_

Maternal Grandfather: \_\_\_\_\_

Siblings: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Diet:**

Breakfast \_\_\_\_\_

Snack \_\_\_\_\_

Lunch \_\_\_\_\_

Snack \_\_\_\_\_

Dinner \_\_\_\_\_

Number of alcoholic beverages consumed per week?

Do you smoke or use illegal drugs?

**Sleep:** Hours slept at night?

Do you wake rested?

**Exercise:**

Hours spent in physical activity per week? \_\_\_\_\_

Types of exercise? \_\_\_\_\_

**Toxicity Exposure**

Number of fillings and crowns? \_\_\_\_\_ How many are mercury (silver)? \_\_\_\_\_

Hobbies? \_\_\_\_\_

Have you ever lived near or worked in agriculture, or major industry? \_\_\_\_\_

Any known toxic exposures? \_\_\_\_\_