



# Uptown Center for Natural Medicine

specializing in hormonal health & weight loss

Dr. Forrest Beck | 1233 Lawrence Street | Port Townsend, WA. 98368

360.385.2107 | (fax) 360.385.2117

www.uptowncenterfornaturalmedicine.com

## Personal Medical History

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

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Age \_\_\_\_\_

Street Address: \_\_\_\_\_ City/St.: \_\_\_\_\_  
Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/St.: \_\_\_\_\_  
Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Where can we leave a message regarding your personal health issues?  
\_\_\_\_\_

Occupation \_\_\_\_\_ Birthplace \_\_\_\_\_

Date of Last Examination \_\_\_\_\_

Previous or other doctors: \_\_\_\_\_

Who suggested you see Dr. Beck? \_\_\_\_\_

Spouse or Partner Name: \_\_\_\_\_

Type of Relationship: \_\_\_\_\_

ALLERGIES (including drugs, food and environmental):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT: (if possible, rank in terms of importance to you)

1. \_\_\_\_\_

2. \_\_\_\_\_

- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Current Medications	Dose	Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Vitamins / Herbs / Supplements	Dose	Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Past Medical, Surgical, & Trauma History**

List prior illness, injury, hospitalization, surgery, and/or trauma:

Event	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any complications with your own birth

\_\_\_\_\_

\_\_\_\_\_

## Personal and Family History

Check all that apply

	Yourself	Mother	Father	Grandparents	Siblings	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Thyroid							
Tuberculosis							
Ulcers							
Other							

## Social History

Check all that apply:

### Marital Status:

- single
- partnership
- married
- divorced
- widowed

### Highest Education Completed:

- high school
- college
- graduate level
- other: \_\_\_\_\_

### Childhood Memories:

- mostly happy
- mostly painful
- normal
- don't recall

### Do You Find Your Life:

- satisfactory
  - unsatisfactory
  - too demanding
  - boring
  - other: \_\_\_\_\_
- 

### Living Arrangement:

- alone
  - family
  - roommate
  - spouse
  - partner
  - children (list name/sex/age): \_\_\_\_\_
- 
- 

### Major Stresses in Last 6 Months

- money
  - job
  - marriage
  - home life
  - children
  - other: \_\_\_\_\_
- 
- 

### Pertinent Travel History (out of USA, epidemic areas, etc.):

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## Lifestyle / Self-Care Issues

Do you smoke cigarettes?  YES  NO If yes, how long? # \_\_\_\_\_ Yrs. \_\_\_\_\_ Packs per day

Did you ever smoke?  YES  NO If yes, when did you quit? \_\_\_\_\_

Do you drink alcohol?  YES  NO If yes, how much?

Type: \_\_\_\_\_ & \_\_\_\_\_ Drinks per week? \_\_\_\_\_

Do you drink caffeinated beverages?  YES  NO

If yes, which? \_\_\_\_\_

Do you use recreational drugs?  YES  NO

If yes, which? \_\_\_\_\_

Do you manage stress well?  YES  NO  NOT SURE  NEED HELP

Do you exercise?  YES  NO

If no, why? \_\_\_\_\_

If yes, how much and how often? \_\_\_\_\_

Do you enjoy your job?  YES  NO

If no, why? \_\_\_\_\_

How many hours per week do you work? \_\_\_\_\_

Do you allow time to unwind and relax?  YES  NO

If no, why? \_\_\_\_\_

Do you sleep soundly?  YES  NO

If no, why? \_\_\_\_\_

Is your diet healthy enough?  YES  NO  NOT SURE  NEED HELP

Are you satisfied with your relationship?  YES  NO

If no, why? \_\_\_\_\_

Are you satisfied with your social life?  YES  NO

If no, why? \_\_\_\_\_

How many ounces of water do you drink per day? \_\_\_\_\_

Height: \_\_\_\_\_ ft \_\_\_\_\_ in

Present weight: \_\_\_\_\_ lbs Weight 1 yr ago: \_\_\_\_\_ lbs Ideal Weight: \_\_\_\_\_ lbs Max Weight: \_\_\_\_\_ lbs

Typical breakfast

\_\_\_\_\_  
Typical lunch

\_\_\_\_\_  
Typical dinner

\_\_\_\_\_  
Typical snacks

Do You Use:

- |                                     |                                       |   |   |
|-------------------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> Eyeglasses | <input type="checkbox"/> Contact Lens | <input type="checkbox"/> Hearing Aid    | <input type="checkbox"/> Brace (Neck, Back) |
| <input type="checkbox"/> Pacemaker  | <input type="checkbox"/> Dentures     | <input type="checkbox"/> IUD, Diaphragm | <input type="checkbox"/> Artificial Limbs   |

## Health Screening History

List the date of your most recent test or exam.

Mammogram \_\_\_\_\_ Rectal Exam \_\_\_\_\_ Scope Lower Bowel \_\_\_\_\_  
 Pap Smear \_\_\_\_\_ Test for Blood in Stool \_\_\_\_\_ Scope Upper Bowel \_\_\_\_\_  
 Self Breast Exam \_\_\_\_\_ Prostate Exam \_\_\_\_\_ Cholesterol \_\_\_\_\_  
 Breast Exam by Doctor \_\_\_\_\_ Self Exam Testicle \_\_\_\_\_ Blood Sugar \_\_\_\_\_  
 Dexa (Bone Density) Scan \_\_\_\_\_ Testicle Exam by Doctor \_\_\_\_\_ Hba1C \_\_\_\_\_  
 Other Blood tests \_\_\_\_\_

## Immunizations

List dates for children and yes/no for adults

DTP = Diphtheria \_\_\_\_\_ Tetanus \_\_\_\_\_ Whooping Cough (Pertussis) \_\_\_\_\_  
 MMR = Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_  
 German Measles \_\_\_\_\_ Polio \_\_\_\_\_ Hemophilus \_\_\_\_\_  
 Chicken Pox \_\_\_\_\_ Hepatitis \_\_\_\_\_ Pneumonia \_\_\_\_\_  
 Flu Shot \_\_\_\_\_

Please list any vaccine complications: \_\_\_\_\_

## Procedures

Please list the date of any procedures:

Anatomy\Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	Pet Scan	EMG
Back							
Brain							
Chest							
Colon							
Arms/ Legs							
Gallbladder							
Kidney							
Neck							
Pelvis							
Stomach							
Other: _____							

## Menstrual Cycle and History

Age of first period \_\_\_\_\_ Cycle:  regular  irregular Length of Menses \_\_\_\_\_  
 Length of Cycle \_\_\_\_\_ #Pads/Tampons per day \_\_\_\_\_ Color? \_\_\_\_\_ Clots? \_\_\_\_\_  
 1st Day of Last Period \_\_\_\_\_ Date of Last Pap Smear \_\_\_\_\_ Was it Regular? \_\_\_\_\_  
 Have you ever had an irregular Pap Smear?  no  yes If yes, date/treatment? \_\_\_\_\_

Do you have any of the following PMS symptoms?  breast tenderness  bloating  mood changes  
 headaches  cravings  other: \_\_\_\_\_

Pain with menses:  NO  YES Severity/Treatment: \_\_\_\_\_

## Sexual History

Currently sexually active:  NO  YES Sexual Relations with:  Men  Women  Both

1 Partner  > 1 Partner If greater than one, how many? \_\_\_\_\_

Age of first sexual intercourse: \_\_\_\_\_ Number of sexual partners in lifetime: \_\_\_\_\_

Type of contraception used: \_\_\_\_\_  satisfied  desire change

Male and Female	Yes/No	Date
HPV		
Herpes		
Chlamydia		
Gonorrhea		
Syphilis		
HIV/AIDS		
Trichomoniasis		
Leakage of urine		
Yeast Infections		
Infertility		
DES Exposure before birth		
Sores/Discharge		
<b>Male Only</b>		
Decreased Sex Drive		
Impotence		
Testicular Pain/Swelling		
<b>Female Only</b>		
Toxic Shock Syndrome		
Pelvic Inflammatory Disease (PID)		
Pain or Bleeding with Intercourse		
Abnormal/Irregular Vaginal Bleeding		
Vaginal Dryness		
Endometriosis		
Ovarian Cysts		
Uterine Fibroids		
Breast Disease		
Breast Surgery		
Cervical Cancer		
Uterine Cancer		
Ovarian Cancer		
Surgery on Ovaries		
Hysterectomy		
Colposcopy		
Cryosurgery		

### Past Pregnancies, Miscarriages or Abortions

Child's Name				
Month/Day/Year				
Week of Delivery				
Length of Labor				
Birth Weight				
Sex M/F				
Type of Delivery Vaginal / C-Section				
Anesthesia				
Hospital or Homebirth				
Preterm Labor Y/N				
Comments / Complications				

**Review of Systems – please check all that apply**

**Age:**

**Date:**

**General**

- Weight change  Fever/chills  Weakness  Fatigue
- Sweating/night sweats

**Skin**

- Rashes  Itching  Hair/nail change

**Head**

- Headache  Head injury  Dandruff  Oily/Dry Hair

**Eyes**

- Vision/glasses  Blurring  Floaters
- Double vision  Pain  Discharge

**Ears**

- Ringing  Discharge  Difficulty hearing
- Recurrent Ear Infxns

**Nose**

- Sinusitis  Discharge  Postnasal drip  Bleeding  Obstruction

**Mouth/Throat**

- Gum bleeding  Toothache  Sore throat  Sores
- Hoarseness  Bad breath  Difficulty swallowing

**Pulmonary**

- Diff. Breathing  Wheezing  Chest pain  Coughing blood
- Chronic cough  TB exposure  Shortness of breath

**Cardiovascular**

- Heart trouble  Hypertension  Sleep with  $\geq 2$  pillows
- Angina pectoris  Murmurs  Swelling of hands/ankles/feet
- Palpitation (flutters)  Blue hands or feet  Claudication (clotting)

**Breasts**

- Masses  Pain  Discharge

**Gastrointestinal**

- Loss of appetite  Abdominal pain  Indigestion  Hernia
- Rectal bleeding  Blood in stool  Constipation
- Anal discomfort  Stool shape, color  Hemorrhoids
- Nausea/Vomiting/Diarrhea

**Genitourinary**

- Painful urination  Waking to urinate  Blood in urine
- Urgency  Frequent Urination  Kidney stones
- Incontinence/dribbling

**Sexual History**

Please note any changes since past visit: \_\_\_\_\_

\_\_\_\_\_

**Female-menses**

- Painful menses  Menopause  Spotting  Irregular menses
- Vaginal discharge  Painful intercourse  Hot flashes
- Vaginal dryness  Decreased sex drive  Vaginal itching
- Cycle duration/amount

**For Physician's Use**

**Endocrine**

- Hormone problem
- Tremor
- Diabetes
- Hormone therapy
- Heat/Cold intolerance
- Excessive thirst/urination

**Allergic**

- Asthma
- Hay fever
- Hives
- Eczema
- Sensitivity to food/allergens/drugs/vaccines/supplements

**Bones, joints & muscles**

- Injury
- Swelling
- Pain/Arthritis

**Other**

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**IF NOT NOTED IT IS EITHER NEGATIVE, NON-CONTRIBUTORY, AND/OR NON-PERTINENT.**

## Informed Consent

### What is informed consent?

Informed consent is the process by which a fully informed patient can participate in choices about her health care. It originates from the legal and ethical right the patient has to direct what happens to her body and from the ethical duty of the physician to involve the patient in her health care.

### What are the elements of full informed consent?

The most important goal of informed consent is that you have an opportunity to be an informed participant in your health care decisions. It is generally accepted that complete informed consent includes a discussion of the following elements:

- your diagnosis in the opinion of the doctor
- the nature of the proposed treatment plan
- the relevant risks, benefits, and uncertainties of the proposed treatment plan
- reasonable alternatives to the proposed treatment plan
- the relevant risks, benefits, and uncertainties related to each alternative
- assessment of your understanding
- your acceptance of the treatment plan

### Is informed consent necessary for my treatment?

The law requires doctors to have a signed informed consent for some procedures, usually surgical in nature. Generally, the treatment plans and procedures recommended by Dr. Beck will not fall into this category. However, he feels as though informed consent is an important part of ensuring your comfort with the proposed treatment plan as well as facilitating your compliance with the plan. Dr. Beck believes that informed consent empowers you to take an active role and responsibility in improving your health.

### Agreement of Informed Consent

By signing below, I acknowledge that I have read and understand this consent form. My signature verifies that by accepting treatment or medications from Dr. Beck, I have discussed to my satisfaction the elements of full informed consent (listed above). Further, I will decline any medication, treatment or procedure in which I feel I have not had the opportunity to give my full informed consent.

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Signature

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Date

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Printed Name

