Teaching Healthy Living for Life

Dr. John Yim, N.D.

Your Naturopathic Specialist
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Dr. Yim and his staff are dedicated to giving you the tools you need to regain and maintain Vital Living! To help us serve your health needs optimally, please complete the following information as accurately as possible. Thank You!

Name ______________________________ M F Date (Mo/Day/Year) _____/_____/_____
Birthdate (Mo/Day/Year) ______/______/______ Age _______________
Street Address ____
City ______________________________________Postal Code________________
Home Phone _____________________Work Phone__________________________
Occupation _______________________________Work Phone ________________
To receive our free e-newsletter please include your email address:
____
Spouse's Name ____
# of Children and Ages ____
If the above is a child: Father's Name _________________________________
If the above is a child: Mother's Name _________________________________
Who referred you to our office? _______________________________________

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us in writing to do so. Please complete this questionnaire as thoroughly as possible. Thank you.

What health concerns/problems brought you to this office today?
____
____
____

Has anything recently changed or become worse?

____
____
____

What questions do you have that you would like answered?

____
____
____

What kind of help do you want or expect to be provided?

____
____
____

Are you being treated for any condition by a physician now? Yes No
Condition _____________________________Physician _____________________

Current Medications
Please list all your prescription medications (such as sleeping pills, birth control pills, etc.),
non-prescription medications (such as aspirin, antacids, laxatives, antihistamines), vitamins,
minerals, herbs, etc., that you take more than occasionally.

____
____
____

Known Allergies
Please list any known allergies to medicines (such as penicillin, sulpha drugs, aspirin, etc.), or other substances (such as pollens, ragweed, etc.), foods, chemicals, etc.

____
____
____

Hospitalizations, Surgeries, Serious Injuries (Date/Reason for hospitalization)

____
____
____

Personal Health Habits
Height _____ Current Weight _____ lbs 1 Year Ago _____lbs
Max. weight ________ Year ____________
Smoker: Yes No Smoked for _______ years. Amount per day ______
Year stopped if applicable____
Alcohol Use: Yes No Type of alcohol preferred __________Frequency_______
Recreational Drug Use: Yes No Type ________________Frequency __________
Coffee: Yes No ______ cups per day   Tea: Yes No ________ per day
Diet: Are there any food groups that you avoid? Yes No If "yes", what
____
____
____

Do you exercise regularly? Yes No Type ______________Duration ___________
Frequency____

Hobbies ____
____
Blood Type (if known) A B O
Women: Are you currently pregnant? Yes No

Medical History

Please circle only those that pertain to YOU personally (unless you are filling this out for a child)

Alcohol Abuse
Allergies
Anemia
Arthritis
Asthma
Back, Muscle, Joint Pain
Gum
Female Gynecological
Problems Skin Problems
Bladder/Urinary Problems
Colitis

Female Gynecological
Problems
Gallstones Stroke
Gum/Teeth Problems
Heart Attack
Heart Problems
High Blood Pressure
Kidney Problems
Liver Problems
Lung Problems
Overweight

Skin
Stroke
Suicide
Thyroid
Tuberculosis
Ulcer
STD (ie HIV, syphilis,
gonorrhea, herpes)
Other:
____
____

Cancer
Depression
Diabetes
Epilepsy
Fatigue, Chronic

Psychological Difficulties ______________________
Rheumatic Fever ______________________
____

Family Medical History
Age Health Problems If Deceased, Cause of Death Age at Death
Father
____
Mother
____
Brothers and Sisters
____
____
Children
____
____

Full payment of services is expected at the time of your visit. If you are unclear of fees please ask the receptionist. There is a fee of $25.00 if cancellations are not made 24 hours prior to appointment.

I have read the above and agree. (Signature of patient or guardian)

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