Cornerstone Family Health Clinic

Dr. Carol Bobovski
13115 121st Way NE, Ste. C
Kirkland, WA 98034
P: (425) 821-1800 / F: (425) 821-1818

Name: ______________________________ **Age:** _______ **Date of Birth:** ____________
Nickname/preferred name: _________________________

List Current Health Concerns

1. ___________________________________ 2. ___________________________________
3. ___________________________________ 3. ___________________________________

Goals/Expectations: ____
____
____
____

What are the most significant measures you have taken to improve your health? ______________
____
____
____

Have you seen a naturopath before? No Yes
Are you currently seeing one? No Yes, Doctor's name: ______________________
Do you currently have a medical doctor? No Yes, Doctor's name: ________________
Are you currently seeing a chiropractor, acupuncturist, counselor, or any other health care professional? If so, please list: ____
____

List the prescribed medications, non-prescription medications, herbals, vitamins, and minerals you are currently taking: ____
____
____
____

Please list any medications you have been prescribed, but are not taking: ____________________
Do you have a history of allergies or reactions? No Yes (please list and include your reaction)

Medications: ____
Environmental: ____
Foods: ____
Other: ____

Please list any major illnesses, hospitalizations, surgeries (date and brief description): _________
____
____
____

Cornerstone Family Health Clinic
Dr. Carol Bobovski
13115 121st Way NE, Ste. C
Kirkland, WA 98034
P: (425) 821-1800 / F: (425) 821-1818

Name: ______________________________

Height: ____________
Weight: ___________ Weight 1 year ago: _____________ Max weight: _____________

Personal and Family History:
Please indicate if you or a family member has experienced the following health complaints

Unknown

AIDS/ HIV ________________
Alcoholism ________________
Allergies __________________
Anemia ___________________
Arthritis ___________________
Asthma ___________________
Cancer ____
Depression _________________
Diabetes ___________________
Drug Problems ______________
Excema ____________________
Gout _______________________

Heart Disease _____________________________________
High Blood Pressure _______________________________
Hypoglycemia _____________
Kidney Disorder ____________
Mental Illness ______________
Migraines __________________
Obesity ____________________
Psoriasis ___________________
Senility ____________________
Sexual Abuse ________________
Seizures ____________________

Stroke _____________
Suicide _____________
TB ________________
Thyroid Disorder _____
Ulcer ______________
High Cholesterol _____

Review of Symptoms:
Circle Yes if experience within the last 1 month

Constitutional ___________________________

Good Recent Health	Yes	No
Recent Weight Change	Yes	No
Night sweats, Fever	Yes	No
Fatigue	Yes	No

Cardiovascular __________________________

Chest pain	Yes	No
Palpitations	Yes	No
Heart Trouble	Yes	No
Swelling hands/ feet	Yes	No
Lightheaded/ dizziness	Yes	No

Endocrine __________________________

Excessive thirst/urination	Yes	No
Hair loss or unusual growth	Yes	No
Cold hands/feet	Yes	No
Hormone Problems	Yes	No

Urinary ____________________________

Blood in urine	Yes	No
Pain/ Burning w/ urination	Yes	No
Kidney Stones	Yes	No
Recurrent Bladder Infections	Yes	No
Difficulty with voiding	Yes	No

Cornerstone Family Health Clinic
Dr. Carol Bobovski
13115 121st Way NE, Ste. C
Kirkland, WA 98034
P: (425) 821-1800 / F: (425) 821-1818

Name: ____________________________

Musculoskeletal ______________________

Symptom		
Muscle pain/cramps	Yes	No
Stiffness/Swelling Joints	Yes	No
Trouble walking	Yes	No

Ears/Nose/Throat/Mouth ______________

Symptom		
Hearing loss or ringing	Yes	No
Sinus problems	Yes	No
Sore throat/voice change	Yes	No

Respiratory____________________________

Symptom		
Shortness of Breath	Yes	No
Cough	Yes	No
Wheezing/Asthma	Yes	No
Difficulty Breathing	Yes	No
Sleep Apnea	Yes	No

Neurological______________________________

Symptom		
Frequent Headaches	Yes	No
Paralysis or Tremors	Yes	No
Seizures	Yes	No
Numbness or Tingling	Yes	No

Skin___________________________________

Symptom		
Rashes or itching	Yes	No
Abnormal Nails	Yes	No
Dry Skin	Yes	No
Discolored Skin	Yes	No
Body Odor/ Excessive Sweat	Yes	No

Male/Female______________________________

Symptom		
Menstrual Problems	Yes	No
Sexual Problems	Yes	No
Testicle/Ovary Pain	Yes	No
Infertility	Yes	No
Breast Concerns (lumps, discharge/ pain)	Yes	No

Eyes___________________________________

Symptom		
Wear glasses/contacts	Yes	No
Blurred/double vision	Yes	No
Eye Disease/Injury	Yes	No
Eye Pain	Yes	No

Hemotologic/Lymphatic__________________

Symptom		
Anemia	Yes	No
Bruise Easily	Yes	No
Slow to Heal	Yes	No
Enlarged Glands	Yes	No

Allergies______________________________

Symptom		
Food Allergies	Yes	No
Hay Fever	Yes	No
Chemical Sensitivity	Yes	No

Psychiatric_____________________________

Symptom		
Depression	Yes	No
Anxiety/Panic Attacks	Yes	No
Confusion/Memory Loss	Yes	No
Insomnia	Yes	No
Suicidal Ideation	Yes	No

Digestion____

Symptom		
Indigestion/Belching/Reflux	Yes	No
Nausea/Vomiting	Yes	No
Early Fullness	Yes	No
Gas/Bloat	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Abdominal Pain	Yes	No
Hemorrhoids	Yes	No
Rectal Bleeding	Yes	No
Mucous in Stool	Yes	No
Abnormal Stool Color	Yes	No

Cornerstone Family Health Clinic
Dr. Carol Bobovski
13115 121st Way NE, Ste. C
Kirkland, WA 98034
P: (425) 821-1800 / F: (425) 821-1818

Name: ___________________________________

Women:
Last menses start date: ___________ Regular cycle Irregular cycle
Painful menses? Yes No
Premenstrual complaints? Yes No If yes, list: ________________________________
Are you planning to conceive now or in the near future? Yes No
If sexually active, what form of birth control do you use? __________________________________

Lifestyle

Stressors: Rate level of stress, (10 = high stress, 1 = low stress): ________________________
Top stressor currently or in recent past, if any: ____

Exercise:
Do you exercise regularly? Yes No
Regimen: ____
Frequency/Duration: ____
How long have you been on this program? _______________________________________

Diet:
Do you eat breakfast? Yes No Time: ________________
Describe typical meal: ____
Do you eat lunch? Yes No Time: ________________
Describe typical meal: ____
Do you eat dinner? Yes No Time: ________________
Describe typical meal: ____
Do you snack? Typical snacks: ____
What are your food cravings, or attractions? ____
Coffee: ________cups/day Caffeinated Tea: _________cups/day Chocolate________/day
Water Intake: _________glasses/day
Are there any foods that disagree with you/or that you avoid (meats, etc)? ____________________
____

Habits:
Do you smoke or chew (tobacco)? Yes No ________packs/day or amount/day
Do you drink alcoholic beverages? Yes No ________drinks per: day week month
Other: ____

Sleep:
Rate the quality of sleep (10 is good, 1 is poor): _________
Anything else you want the doctor to know: ____

☐ Reviewed with patient ________________