

Heart Spring Health

Serron Wilkie ND 4804 SE Lincoln St. Portland OR 97215 503-956-9396

Patient Information:

Name: _____ Date: _____
Address: _____ Apartment: _____
City: _____ State: _____ Zip Code: _____
Phone- Day: () _____ Evening:() _____ Cell:() _____ Preferred: _____
Message OK: Y N E-mail address: _____
Age: _____ Date of Birth: _____ Gender: female ___ male ___
Married ___ Partnered ___ Separated ___ Divorced ___ Widowed ___ Single ___
Housing: Spouse/Partner ___ Parents ___ Children ___ Friend/Roommate ___ Alone ___
Occupation: _____ Hours per week: _____ Retired: _____
Employer: _____ S.S.#: _____
(Work address): _____

Emergency contact: _____
Relationship: _____ Phone: _____
Address: _____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

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What expectations do you have from this visit?

- What long-term expectations do you have?
- What expectations do you have of me as your physician?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health and in adhering to the therapeutic protocols, which we will be sharing with you?

6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

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Are you currently receiving healthcare? Y N

If yes, where and from whom: _____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance:

1) _____

2) _____

3) _____

4) _____

5) _____

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now **N**=Never had **P**=Significant problem in the past

Habits/Environment:

Do you enjoy your work?	Y N	Sleep well?	Y N
Do you take vacations?	Y N	Average 8 hrs. sleep?	Y N
Do you watch television?	Y N	Awaken rested?	Y N
How many hours? _____		What is your best time of day? _____	
What is restful and restorative for you? _____		Worst time of day? _____	
What gives you purpose and meaning? _____		Do you eat 3 meals a day?	Y N
Do you have a religious or spiritual practice? Y N		Favorite foods? _____	
If yes, what? _____		Do you eat protein with every meal?	Y N
Do you exercise? Y N		Do you go on diets?	Y N P
If yes, what kind? _____		Do you eat a special diet?	Y N P
How many days/wk? _____		Type of diet you follow? _____	
For how long? _____		Are there foods that you know do not agree with you? Y N	
Fresh air and exposure to sun? How often? _____		If so, which foods? _____	
		Do you add salt?	Y N P

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Do you eat sugar?	Y N P	Date of last tobacco: _____
Drink coffee, black/green tea, energy drinks or soda? (please circle all that apply)	Y N P	Smoked for how many years? _____
Do you eat chocolate?	Y N P	How many packs per day? _____
Do you eat out often?	Y N	Use alcoholic beverages? Y N P
Water intake/day? _____		Treated for alcoholism? Y N P
Exposure to environmental toxins? Y N P		Use recreational drugs? Y N P
Do you use tobacco? Y N P		Been treated for drug dependence? Y N P
Think about quitting? Y N		

Family History

Do you have a family history of any of the following? Please circle and follow with **brief** description of **type** of disease (e.g. breast cancer, depression etc.) and who in your family was affected.

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Mental Illness	Autoimmune disease
Asthma	Anemia		

Any other relevant family history? _____

Childhood Illnesses

Please circle if you had any of these as a child or an adult (please indicate if you got them as an adult):

Scarlet fever	Diphtheria	Rheumatic fever
Mumps	Measles	German measles

Are your immunizations up to date? _____

Please list any you believe you need: _____

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, Dental work, X-Rays, CAT Scans, ultrasounds, EEG, EKG's, Mammogram, Bone scan, DEXA, Colonoscopy, lung function tests have you had?

_____ year: _____	_____ year: _____
_____ year: _____	_____ year: _____
_____ year: _____	_____ year: _____

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Major events or health conditions that occurred during your lifespan:

0-5
years _____

5-10
years _____

10-15
years _____

15-20
years _____

20-30
years _____

30-40
years _____

40-50
years _____

50-60
years _____

60+
years _____

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

Medications:

Circle any you have taken before

- | | | | |
|---------------|-----------------------|-----------------|---------------------|
| Laxatives | Appetite suppressants | Sleeping pills | Allergy meds |
| Pain reliever | Antibiotics | Stimulants | Hormone replacement |
| Antacids | Tranquilizers | Antidepressants | Asthma meds |
| Cortisone | Thyroid medication | Diabetic meds | |

Others:

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Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are **currently** taking? **Please list doses and frequency**

- | | |
|----------|-----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |
| 7) _____ | 8) _____ |
| 9) _____ | 10) _____ |

General

Height: _____ Weight: _____ lbs. Birth weight _____ (if known) Fever or chills? Y N

Recent change in weight? Y N if so, how much? _____ Weight 1 year ago: _____ lbs

Maximum Weight: _____ When: _____

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P
Lightheaded	Y N P		

Eyes

Spots in Eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

Ears

Hearing loss?	Y N P	Ringling?	Y N P
Earache or pain?	Y N P	Dizziness?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stiffness or discharge?	Y N P	Hayfever?	Y N P
Sinus pain or problems?	Y N P	Loss of smell?	Y N P
Itching?	Y N P		

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

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Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Difficulty breathing w/ exercise?	Y N P
Shortness of breath at night?	Y N P	“ “ “ lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Chest pain?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Palpitations/Fluttering?	Y N P	Fainting?	Y N P
Rheumatic Fever?	Y N P	Phlebitis?	Y N P
Swelling in ankles?	Y N P	Shortness of breath w/ exertion?	Y N P

Gastrointestinal

Trouble swallowing?	Y N P	Excessive bloating?	Y N P
Heartburn?	Y N P	Ulcer?	Y N P
Reflux?	Y N P	Jaundice (yellow skin)?	Y N P
Change in appetite?	Y N P	Gall Bladder disease?	Y N P
Nausea/vomiting	Y N P	Liver Disease?	Y N P
Coughing up blood?	Y N P	Bowel Movements:	
Hemorrhoids?	Y N P	How often? _____ times a day/week	
Constipation?	Y N P	Straining while passing stool?	Y N P
Diarrhea?	Y N P	Undigested food in stool?	Y N P
Abdominal pain or cramps?	Y N P	Black stools?	Y N P
Belching or passing gas?	Y N P	Loose or narrow stools?	Y N P

Urinary

Urgency with urination?	Y N P	Pain on urination?	Y N P
Increased frequency?	Y N P	Frequency at night?	Y N P
Cloudy urine or blood in urine?	Y N P	Changes in force of stream?	Y N P
Hesitancy or dribbling with urination?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

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Female Reproduction / Breasts

Age of first menses? _____	Number of pregnancies: _____	
Age of last menses? (if menopausal) _____	Number of live births: _____	
Length of cycle? _____ days	Number of miscarriages: _____	
Duration of menses? _____ days	Number of abortions: _____	
Cycles regular? Y N P	Difficulty conceiving? Y N P	
Date of last annual exam/ PAP _____	Pain during intercourse? Y N P	
Bleeding between cycles? Y N P	Ovarian cysts? Y N P	
Clotting? Y N P	Endometriosis? Y N P	
Painful menses? Y N P	Abnormal PAP? Y N P	
Heavy or excessive flow? Y N P	Cervical Dysplasia? Y N P	
Explain: (pads/tampons per day) _____	Menopausal symptoms? Y N P	
	Sexual difficulties? Y N P	
PMS? Y N P	Chlamydia? Y N P	
If yes, what are your symptoms? _____	Gonorrhea? Y N P	
	Condyloma? Y N P	
Vaginal discharge? Y N P	Herpes? Y N P	
Itching? Y N P	Syphilis? Y N P	
Sores or lumps? Y N P	Breasts:	
Are you sexually active? Y N	Do you do breast self exams? Y N P	
Sexual orientation: _____	Breast pain/tenderness? Y N P	
Birth control? Y N P	Breast lumps? Y N P	
What type? _____	Nipple discharge? Y N P	

Male Reproduction

Hernias? Y N P	Discharge or sores? Y N P
Testicular pain? Y N P	Testicular masses? Y N P
Prostate disease? Y N P	Are you sexually active? Y N
Venereal disease? Y N P	Sexual orientation: _____
Chlamydia? Y N P	Birth control? Type? _____
Gonorrhea? Y N P	Syphilis? Y N P
Impotence? Y N P	Condyloma? Y N P
Premature ejaculation? Y N P	Herpes? Y N P

Musculoskeletal

Joint pain or stiffness? Y N P	Arthritis? Y N P
Broken bones? Y N P	Weakness? Y N P

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Muscle spasms or cramps?	Y N P	Gout?	Y N P
<u>Blood / Peripheral Vascular</u>			
Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P
Blood clots?	Y N P	Past transfusions?	Y N P
<u>Immune</u>			
Chronic infections?	Y N P	Autoimmune condition?	Y N P
Reactions to immunizations?	Y N P	Chronic Fatigue?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P
<u>Endocrine</u>			
Hypo or hyper thyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive sweating?	Y N P
Fatigue?	Y N P	Excessive thirst or hunger?	Y N P
<u>Neurologic</u>			
Fainting?	Y N P	Seizures?	Y N P
Paralysis?	Y N P	Muscle weakness?	Y N P
Numbness or tingling?	Y N P	Tremors or twitches?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P
<u>Skin</u>			
Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils, or sores?	Y N P	Itching?	Y N P
Color Change?	Y N P	Perpetual Hair Loss?	Y N P
Lumps, bumps, growths?	Y N P	Night Sweats?	Y N P
<u>Mental / Emotional</u>			
Treated for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Tension?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P
Have a history of abuse?	Y N	Any major traumas?	Y N P