Dr. Suzanne Scopes, N.D.
2326 NW Lovejoy St.
Portland, OR 97210
(503) 230-0812

Welcome! Your completion of this health history questionnaire will provide us with essential information to provide you with the best care. Please feel free to ask questions. Your participation in your health care is an important part of the process.

Confidential Patient Information

Patient Name (Legal/Name on Insurance):_____
What name do you prefer?_____
Gender: M / F / FTM / MTF / Other_____ **Gender on insurance if differen**t: _____
Pronoun Preference: _____

Date of Birth: _____

Address: _____

City, State, ZIP:_____

Mobile/Cell Phone: _____ **Work Phone:** _____ **OK to leave msg?** _____

Email address:_____

Emergency Contact:_____ **Phone:**_____

Number and ages of children: _____

Employed: Full-time____ Part-time____ Stay at home parent____ Unemployed/retired____ Disabled____

Employer: _____ Occupation:_____
School: Full-time___ Part-time___ Name of School:_____
Whom may we thank for this referral?_____
Primary Health Concerns**********
Primary reason for visit: _____
Other health concerns: _____
Past Medical Care
When and where did you last receive medical care? For what reason?_____
_____
Name of primary care doctor: _____ Date of last physical:_____
Name of dentist:_____ Date of last dental exam:_____
Allergies to medications: _____
Other allergies:_____
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Method of Payment: Personal payment: _____Medical Insurance: _____ Other: _____
If your services are covered by insurance, please complete the insurance page.

Please read and sign below:
I understand that I am responsible for payment of all office visits, procedures, supplements, supplies, lab tests and lab handling fees provided by Suzanne Scopes, ND. I agree to make payment in full at the time of the visit, unless other arrangements are made. In any event, I will be responsible for all costs of collection, including reasonable attorney fees, if I fail to make timely payments.
Patient Signature: _____ **Date:**_____

Health History********
My general state of health has been: _____ excellent _____ good _____ fair _____ poor
List all medications with dosages (prescription and over-the-counter) that you take:

_____

_____

List all vitamins, herbs and other supplements that you take:

_____

Past medical history: (please include dates)

Major Illnesses or injuries_____

Surgeries_____

Mark the following with a "C" for current and "P" for past problems:

___Allergies	___Ear infections	___Pneumonia
___Alcoholism/drug addiction	___Eczema/Psoriasis	___Polio
___Anemia	___Epilepsy	___Prostate problems
___Anxiety	___Gallbladder problems	___Rheumatic fever
___Arthritis	___Headaches, frequent	___Sinus problems
___Asthma	___Heart problems	___Stroke
___Autoimmune illness	___Hepatitis, liver problems	___Thyroid problems
___Blood disease	___High blood pressure	___Tuberculosis
___Cancer (Type:_____)	___High cholesterol	___Ulcers
___Colds, frequent	___HIV	___Urinary infections
___Colitis	___Hypoglycemia	___Urinary leakage
___Depression	___Kidney problems	___Sexually transmitted infections
___Diabetes	___Mental illness	Type:_____
___Digestive problems	___Osteoporosis or low bone density	___Other_____

Any exposure to toxic substances (lead, paint, pesticides, etc?)**:** _____

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Gynecological Health

Date of last menstrual period:_____ **Post-menopausal?** Y N
Periods last:_____ days and cycle between periods is _____ days.
Please circle: Are periods regular? Y N Heavy? Y N Cramps? Y N
Premenstrual syndrome? Y N Please describe: _____
Bleeding or spotting between periods? Y N Please describe amount and timing in cycle: _____
Sexually active? Y N **Partner(s)** gender identity_____
Method of birth control, if applicable:_____
Number of pregnancies (all):___ Number of live births:___ (vaginal delivery___, cesarian section___)
Number of abortions___ miscarriages___ stillbirths___
History of vaginal infections: ___yeast ___bacterial vaginosis (gardnerella) ___Chlamydia ___Gonorrhea ___ Herpes ___HPV (venereal warts/condyloma) Other:_____
Abnormal Pap smears? Y N Dates, diagnosis, treatment:_____
Date of last Pap smear:_____ Normal? Y N
Monthly self breast exams? Y N
Date and location of last mammogram:_____
Any abnormal mammograms? Y N Dates:_____

Family History********
Race/Ethnicity: _____

Please place an "X" in the appropriate column for any diseases in your blood relatives

	Mother	Father	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Brothers/ Sisters	Aunts/ Uncles
Living (L) or Deceased (D)								
Age (current or at death)								
Alcohol/drug addiction								
Allergies								
Alzheimer's/Dementia								
Arthritis (type if known)								
Asthma								
Autoimmune disease								
Blood disease								
Cancer (type and what age)								
Diabetes (type and what age)								
Epilepsy								
Glaucoma								
Heart disease (what age)								
High blood pressure								
High cholesterol								
Mental illness (type)								
Osteoporosis or loss of height								
Stroke (type if known)								
Thyroid problems								
Weight problems								
Other major illness (type)								

Health Habits
Exercise: Type_____ How often?_____

Sleep: _____hours per night; ____light ____sound ____insomnia (difficulty falling____ or staying asleep ____)

Stress level: ____high ____average ____low Major stressors_____

Alcohol: Y N If yes, how much, how often? _____
Tobacco: Y N If past, when did you quit? _____ If yes, how much, how long?_____
Marijuana: Y N If yes, how often, how long, what form?
Other drug use:_____ If no, any heavy use in the past? Y N
Alcohol/drug treatment (include dates): _____
Diet: **(circle all that apply)**
Fast food / Standard American (meat, potatoes, dessert) / Natural foods / Vegetarian / Vegan / Raw / Keto/ Paleo
Dairy or Calcium fortified products? Y N How many servings per day_____ or per week_____
Caffeinated beverages? Y N Type: _____ How many ounces per day_____ or per week_____
Briefly describe your typical diet:

Breakfast:
Lunch:
Dinner: