Wilkinson Wellness Clinic
3999 Englewood Ave Suite 201 * Yakima WA, 98902
Phone: (509)453-5506 * Fax: (509)424-3196

Patient Medical History

Patient Name: _____ Date of Birth: _____ Date: _____
Weight: _____ Gender: Male / Female Marital Status (circle one): Single Married Divorced Widowed

Past Medical History	Dates
Anemia or history of blood transfusion	
Autoimmune disorder (SLE, Graves, etc.)	
Cancer (describe)	
Candida- Yeast infection- Thrush	
CFS or Fibromyalgia	
Diabetes	
Fatigue (describe, under what conditions)	
Fever or frequent infections	
Generalized weakness	
Heart disease	
Hepatitis	
High blood pressure	
HIV/AIDS	
Hormone imbalance (see page 4)	
Pain/aching	
Where:	
Describe (sharp, dull etc.):	
How long:	
Under what conditions:	
Rheumatic fever	
Seizures	
Swollen glands	
Thyroid disease	
Other (any hospitalizations):	

Family Medical History	Which Relative
Cancer	
Diabetes	
Heart attack or heart disease	
Hepatitis or liver disease	
High Blood Pressure	
HIV/AIDS	
Obesity	
Seizures	
Thyroid disease	
Dementia/Alzheimer's	
High Cholesterol	

Personal Habits		
Smoke packs/day		
Quit smoking years ago		
Chew tobacco	YES	NO
Coffee cups/day		
Tea cups/day		
Carbonated beverages /day		
Water cups/day		
Drink alcohol	YES	NO
If yes: Daily Frequently Occasionally Rarely (circle one)		
Recreational drugs or marijuana	YES	NO
Alcoholism	YES	NO
Wear nail polish	YES	NO
Wear acrylic nails	YES	NO
Use cosmetics	YES	NO
Get regular exercise	YES	NO
Type: How often:		
Hours of sleep nightly:		
How often do you get up at night:		
Sleep aids:		
Hours worked per week:		
What do you do to relax:		
Spiritually: Do you pray? Meditate? Practice Yoga? Other?		

X-Rays, Scans, Endoscopy	Dates
Abdomen	
Back	
Chest	
Colon	
Extremities	
Full body scan/heart scan	
Gallbladder	
Kidney	
CT scan or MRI of:	
Endoscopy of Colonoscopy	

Surgeries/Organs removed	Dates

Significant Trauma (Accidents, Falls, Etc.)	Dates

Dental	Dates
Metal amalgam fillings	
If removed, when:	
TMJ (clenching, grinding)	
Snoring/sleep apnea	
Root canals	
Wisdom teeth extracted	
Crowns/caps	
Metal used:	
Braces/retainer	
Sensitive teeth/sensitive gums	
Dentures	
Last dental cleaning	
Last dental exam	
Last dental images (x-rays)	
Dental problems	
Other:	

Allergies/Sensitivities		
Carpet / furniture / cabinets	YES	NO
Chemicals	YES	NO
Cologne smells like bug spray	YES	NO
Cologne, scented products	YES	NO
Dust	YES	NO
Fabric	YES	NO
Food	YES	NO
List:		
Metals	YES	NO
Mold	YES	NO
Pesticides, fumigation	YES	NO
Pollen	YES	NO
Smoke	YES	NO
Suspect you are allergic but don't know to what	YES	NO
Other allergies	YES	NO
List:		

Wilkinson Wellness Clinic
3999 Englewood Ave Suite 201 * Yakima WA, 98908
Phone: (509)453-5506 * Fax: (509)424-3196

Patient Medical History

Patient Name: _____ Date:_____

General		
Cold Feet	YES	NO
Cold hands	YES	NO
Cravings	YES	NO
Excess sleep	YES	NO
Excessive thirst (mouth feels like cotton)	YES	NO
Heavy appetite	YES	NO
Insomnia	YES	NO
Low blood sugar	YES	NO
Peculiar tastes/smells	YES	NO
Poor Appetite	YES	NO
Poor/restless sleep	YES	NO

Skin & Hair		
Acne/pimples	YES	NO
Athletes foot	YES	NO
Burning on bottom of feet	YES	NO
Change in skin/hair texture	YES	NO
Changing moles Where:	YES	NO
Crawling sensation	YES	NO
Dry skin	YES	NO
Flushing	YES	NO
Hives	YES	NO
Itching	YES	NO
Oily skin	YES	NO
Rashes	YES	NO
Pale skin	YES	NO
Pigmentation/brown spots	YES	NO
Other:		

Eyes, Ears, Nose, Throat		
Blindness or decreased vision	YES	NO
Bright flashes	YES	NO
Cataracts	YES	NO
Color blindness	YES	NO
Blurred/tunnel vision	YES	NO
Contact lenses	YES	NO
Dark circles under eyes	YES	NO
Eye pain	YES	NO
Eye strain	YES	NO
Floaters in eyes	YES	NO
Glaucoma	YES	NO
Gritty feeling in eyes/dry eyes	YES	NO
Halos around lights	YES	NO
Poor night vision	YES	NO
Sensitive to sunlight or strong light	YES	NO
Swollen, reddened, or sticky eyelids	YES	NO
Deafness	YES	NO
Drainage from ears	YES	NO
Earaches/ear infections	YES	NO
Hearing aids	YES	NO
Hearing loss	YES	NO
Itching in ear canal	YES	NO
Itching or redness from wearing earrings	YES	NO
Ringing or buzzing in ears	YES	NO

Chills	YES	NO
Dizziness (vertigo)	YES	NO
Fatigue	YES	NO
Fevers	YES	NO
Night sweats	YES	NO
Poor heat/cold tolerance	YES	NO
Rarely sweat	YES	NO
Sudden energy drop (time:)	YES	NO
Sweat easily	YES	NO
Tired upon awakening (feel like you haven't slept) YES/ NO		
Other:		

Skin & Hair		
Brittle nails	YES	NO
Bruise easily	YES	NO
Cuts heal slowly	YES	NO
Dandruff	YES	NO
Eczema	YES	NO
Hair Loss	YES	NO
Crown Sides Front Hair line Diffuse sudden		
Nail fungus	YES	NO
Peeling or cracking of skin on feet	YES	NO
Psoriasis	YES	NO
Split or ridged nails	YES	NO
Sweating	YES	NO
White spots on nails	YES	NO
Other skin/hair problems:		

Eyes, Ears, Nose, Throat		
Excessive mucous	YES	NO
Nasal polyps	YES	NO
Nose bleeds	YES	NO
Runny nose	YES	NO
Sinus problems	YES	NO
Sneezing attacks	YES	NO
Stuffy nose	YES	NO
Bleeding gums	YES	NO
Canker sores	YES	NO
Chronic coughing	YES	NO
Cold sores	YES	NO
Cracking around lips/ white tongue	YES	NO
Frequent sore throats	YES	NO
Enlarged glands	YES	NO
Gagging/frequent need to clear throat	YES	NO
Grinding teeth	YES	NO
Hoarseness	YES	NO
Discoloration of gums	YES	NO
Other gum problems	YES	NO
Swallowing difficulty	YES	NO
Swollen or discolored tongue, gums, or lips	YES	NO
TMJ problems	YES	NO
Tonsillitis	YES	NO
Other:		

Wilkinson Wellness Clinic
3999 Englewood Ave Suite 201 * Yakima WA, 98908
Phone: (509)453-5506 * Fax: (509)424-3196

Patient Medical History

Patient Name: _____ Date:_____

Cardio Vascular		
Abnormal electrocardiogram (EKG)	YES	NO
Angina (heart / chest pain)	YES	NO
Awaken from sleep with shortness of breath	YES	NO
Blood clots	YES	NO
Coronary Heart Scan (calcium score)	YES	NO
Difficulty breathing	YES	NO
Enlarged heart	YES	NO
Fainting	YES	NO
Heart attack	YES	NO
Heart murmur	YES	NO
Heart surgery	YES	NO
High blood pressure	YES	NO
Holter monitor	YES	NO

Cardio vascular		
High cholesterol	YES	NO
Irregular/skipped heartbeats	YES	NO
Low Blood Pressure	YES	NO
Numbness of hands/feet	YES	NO
Pacemaker	YES	NO
Phlebitis	YES	NO
Rapid heartbeats	YES	NO
Swollen hands/feet	YES	NO
Varicose veins	YES	NO
Echocardiogram (heart ultrasound)	YES	NO
Treadmill stress test	YES	NO
Other:		

Respiratory		
Allergies	YES	NO
Asthma	YES	NO
Cough	YES	NO
Coughing blood	YES	NO
Difficulty breathing	YES	NO
Low exercise tolerance	YES	NO
Pain with deep breathing	YES	NO
Shortness of breath with activity or at rest	YES	NO
Sleep apnea	YES	NO
Tuberculosis	YES	NO

Respiratory		
Abnormal chest x-ray	YES	NO
History of bronchietasis	YES	NO
Cystic fibrosis	YES	NO
Chest congestion	YES	NO
COPD or Emphysema	YES	NO
History of Pneumonia	YES	NO
Lung Nodules or calcium deposits	YES	NO
Use inhalers or wheezing	YES	NO
Other:		

Gastrointestinal		
Abdominal pain/cramps	YES	NO
Alternating constipation and diarrhea	YES	NO
History of appendicitis	YES	NO
Appetite – poor	YES	NO
Appetite - excessive	YES	NO
Bad breath or bad taste in your mouth	YES	NO
Black or bloody stools	YES	NO
Bloated feeling/ abdominal distention	YES	NO
Bowel habit changes	YES	NO
Colon or bowel trouble	YES	NO
Colon Polyps	YES	NO
Constipation	YES	NO
Crohn's or ulcerative colitis	YES	NO
Diarrhea, persistent	YES	NO
Diverticulosis or diverticulitis	YES	NO
Frequent blenching/flatulence or gas	YES	NO
Gallbladder attacks or stones	YES	NO
Heliobacter pylori	YES	NO

Gastrointestinal		
Hiatial hernia	YES	NO
Heartburn or GERD	YES	NO
Hemorrhoids	YES	NO
Indigestion	YES	NO
Nausea	YES	NO
Nervous stomach	YES	NO
Parasites	YES	NO
Persistent flatulence or gas	YES	NO
Rectal itch or pain	YES	NO
Rectal bleeding	YES	NO
Sensitive abdomen	YES	NO
Sweets upset	YES	NO
Ulcers	YES	NO
Vomiting blood	YES	NO
Bowel movements (how often) per day:		
Laxative use: per week: type:		
Other:		

Wilkinson Wellness Clinic
3999 Englewood Ave Suite 201 * Yakima WA, 98908
Phone: (509)453-5506 * Fax: (509)424-3196

Patient Medical History

Patient Name: _____ Date: _____

Genito-Urinary		
Frequent urination	YES	NO
Interstitial cystitis	YES	NO
Kidney pain (mid back)	YES	NO
Pain on urination	YES	NO
Problem passing urine	YES	NO
Transgender (trans-female or trans-male)	YES	NO
Trouble holding urine/incontinence	YES	NO
Urgency to urinate	YES	NO

Genito-Urinary		
Blood in urine	YES	NO
H/O kidney infection	YES	NO
Kidney stones	YES	NO
Sexually transmitted disease	YES	NO
List:		
Wake up to urinate: how often /night		
Other:		

Male reproductive/genitalia		
Diminished sex desire	YES	NO
Enlarged prostate gland	YES	NO
Erection problems/Impotency	YES	NO
Hernia	YES	NO
Lump in testicles	YES	NO
Night time erections	YES	NO
Penis discharge	YES	NO
Peyroinne's disease (abnormal curvature of penis)	YES	NO

Male reproductive/genitalia		
Premature ejaculation	YES	NO
Sore or lesion on penis	YES	NO
Where:		
Have you tried Viagra, Cialis, or Levitra	YES	NO
Have you tried testosterone	YES	NO
Other:		

Pregnancy & Gynecology		
Age of first menses (period):		
Number of pregnancies: Number of births: Miscarriages:		
Tubal pregnancies: Yes No If Yes, How many:		
Flow: Heavy / light / clots / (circle one)		
Period duration:		
Last mammogram:		
Last menstrual cycle:		
Last pap smear:		
Abnormal pap when:	YES	NO
If so what treatment (repeat pap, cryotherapy/freezing, or medication)		
Birth control type:		
Hormone replacement: which?	YES	NO
Menopause (date):	YES	NO
Last pelvic sonogram (ultrasound)?	YES	NO
Breast lumps	YES	NO

Pregnancy & Gynecology		
Low sex drive	YES	NO
Endometriosis	YES	NO
Fibroid Uterus	YES	NO
Hot flashes or night sweats	YES	NO
Infertility, difficulty getting pregnant	YES	NO
Irregular periods	YES	NO
Menstrual cramps or spotting	YES	NO
Nipple discharge or cramps	YES	NO
Pain with intercourse	YES	NO
Pelvic pain	YES	NO
PMS (moody, cravings, breast tenderness, bloating)	YES	NO
Ovarian Cysts or PCOS	YES	NO
Vaginal discharge or itching	YES	NO
Vaginal dryness	YES	NO
Other:		

Musculoskeletal		
Pain: Where:		
Stiffness: Where:		
Swelling: Where:		
Enlarged knuckles or bumps on joints	YES	NO
Where:		
Head injury	YES	NO
Concussion	YES	NO
Whiplash	YES	NO
Low back stiffness	YES	NO
Loss of consciousness	YES	NO
Mobility problems	YES	NO
Osteoporosis or Osteopenia	YES	NO
Tightness between shoulder blades	YES	NO

Musculoskeletal		
Rheumatoid Arthritis	YES	NO
Joint swelling	YES	NO
Muscle weakness, numbness or tingling	YES	NO
Bump on bones	YES	NO
Damp weather causes aching	YES	NO
Body or face not symmetrical	YES	NO
Pain or popping in jaw	YES	NO
Sciatica	YES	NO
Joint pain where:	YES	NO
Joint surgery where:	YES	NO
Do you use a cane?	YES	NO
Other:		

Wilkinson Wellness Clinic
3999 Englewood Ave Suite 201 * Yakima WA, 98908
Phone: (509)453-5506 * Fax: (509)424-3196

Patient Medical History

Patient Name: _____ Date: _____

Neuro-psychological		
Anger, irritability	YES	NO
Anxiety, fear, nervousness (Panic attacks)	YES	NO
Bipolar (elevated & depressed mood, addictions)	YES	NO
Concussions or blunted head trauma	YES	NO
Confusion	YES	NO
Cry often or easily	YES	NO
Depression	YES	NO
Do you want a referral for counseling?	YES	NO
Do you have a family history for mental disorders?	YES	NO
Drug addiction	YES	NO
Easily stressed or overwhelmed	YES	NO
Eating disorder (Anorexia or Bulemia)	YES	NO
Schizophrenia	YES	NO
Fatigue or sluggishness	YES	NO
Feel inferior	YES	NO
Feel like life is demanding/stressful	YES	NO
Feel like life is unsatisfactory	YES	NO
Friends tell you that you drink too much	YES	NO
Hair loss	YES	NO
Have you been hospitalized for depression	YES	NO
Headaches(stress, tension, migraines, cluster)	YES	NO
Where? Front Back Sides when?		
History of seizures	YES	NO
Hyperactivity or ADD	YES	NO
Insomnia (cant go to sleep or awaken from sleep)	YES	NO

Neuro-psychological		
Alzheimer's or Parkinson's	YES	NO
Areas of numbness or tingling	YES	NO
Where:		
Have you ever considered or attempted suicide	YES	NO
Are you suicidal now	YES	NO
Have you seen a counselor or psychiatrist	YES	NO
Multiple personality disorder	YES	NO
Mood swings	YES	NO
Slurred speech	YES	NO
Sense of despair or socially isolated	YES	NO
Stuttering, stammering	YES	NO
Learning disabilities (dyslexia)	YES	NO
Leg or arm weakness	YES	NO
Have you taken meds for anxiety or depression	YES	NO
Phobias, irrational fears	YES	NO
Poor concentration or coordination	YES	NO
Strokes (mini-stroke or TIA)	YES	NO
Poor memory or forgetfulness	YES	NO
Restlessness	YES	NO
Treatment for emotional problems	YES	NO
Tremors (shaking, twitching)	YES	NO
Worry frequently	YES	NO
Startled at night, nightmares, or vivid dreams	YES	NO
Nervous breakdown	YES	NO
Other:		

Medical Problems Not Covered Elsewhere		
Recurrent skin infections	YES	NO
Broken bones	YES	NO
Cirrhosis or liver disease	YES	NO
Gout	YES	NO
Goiter (enlarged thyroid)	YES	NO
Mononucleosis	YES	NO
Drug reaction	YES	NO
Biopsies	YES	NO

Medical Problems Not Covered Elsewhere		
Obesity	YES	NO
Parasites	YES	NO
Abnormal blood clotting	YES	NO
Polio	YES	NO
Rheumatic fever	YES	NO
Slow metabolism	YES	NO
Warts	YES	NO
Other:		

Electromagnetic Radiation		
Frequent x-rays	YES	NO
Live under or around power lines	YES	NO
Use a cellular or portable phone	YES	NO
Do you use an ear piece for your cell phone	YES	NO

Electromagnetic Radiation		
Use a water bed or electric blanket	YES	NO
Work with computers	YES	NO
Other radiation exposure	YES	NO
Describe:		

Birth Factors –"were you…"		
Birth trauma (describe)		
Bottle fed	YES	NO
Breast fed	YES	NO
Adopted	YES	NO

Birth Factors –"were you…"		
Is medical info available from birth parents	YES	NO
Casarean section or forceps delivery	YES	NO
Premature	YES	NO
Unknown	YES	NO

Wilkinson Wellness Clinic
3999 Englewood Ave Suite 201 * Yakima WA, 98908
Phone: (509)453-5506 * Fax: (509)424-3196

Patient Medical History

Patient Name: _____ Date:_____

Risk of Exposure

Circle the corresponding number for Questions A-E Below (0) Never (1) Rarely (2) Monthly (3) Weekly (4) Daily	
a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)	0 1 2 3 4
b. How often are pesticides used in your home?	0 1 2 3 4
c. How often do you have your home treated for insects?	0 1 2 3 4
d. How often are you exposed to nail polish, perfume, hair spray, and other cosmetics?	0 1 2 3 4
e. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	0 1 2 3 4
Circle the corresponding number for the questions below (0) No (1) Mild Change (2) Moderate Change (3)Drastic Change	
Have you noticed any negative change in your health since you moved into your home or apartment?	0 1 2 3
Have you noticed any negative change in your health since you started your new job?	0 1 2 3
Do you have a water purification system in your home?	YES NO
Do you have any indoor pets?	YES NO
Do you have an air purification system in your home?	YES NO
Are you a dentist, painter, farm worker, or construction worker?	YES NO

Describe your work history. Include exposure to chemicals, fumes, pesticides, metals, heavy lifting, electromagnetic fields, radiation, asbestos, high stress, and anything that may be health related.
Dates: Description of work:
Dates: Description of work:
Briefly describe where you have lived since childhood – part of country/world, in city/rural, etc., and potential exposures from ill patient, unusual neighbors' occupations (cattle rearing, farming, raising pigeons or turtles) etc
Describe your hobbies, sports, and forms of recreation, with attention to exposure as listed under work history
Are you interested in a weight program?
What diets or weight loss programs have you tried and were you successful?
Is there anything else you would like to let us know?
What is your biggest concern that you would like to discuss today?

Wilkinson Wellness Clinic
3999 Englewood Ave Suite 201 * Yakima WA, 98908
Phone: (509)453-5506 * Fax: (509)424-3196

Patient Medical History

Patient Name: _____ Date: _____

Circle the corresponding number for the items below
(0) –No or Never
(1) –Yes or Sometimes
(2) –Often

Nutritional								
Abnormal thirst	0	1	2		Age spots	0	1	2
Avoid cruciferous vegetables	0	1	2		Avoid exercise	0	1	2
(e.g. cauliflower, brussel sprouts, asparagus)					Bulemia (binge / purge)			
Avoid red fruits or vegetables	0	1	2		Cholesterol above 200	0	1	2
(e.g. tomatoes, cranberries, cherries)					Difficulty gaining or maintaining weight			
Bad breath	0	1	2		Difficulty losing weight even on a diet	0	1	2
Appetite loss, anorexia	0	1	2		Difficulty strengthening muscles	0	1	2
Consume commercially produced dairy products	0	1	2		Drink chlorinated water	0	1	2
Consume hydrogen fats	0	1	2		Drink non-filtered water	0	1	2
Craving for alcohol	0	1	2		Drink sweet beverages	0	1	2
Raving for bread, starches, or pasta	0	1	2		Eat candy or sweets	0	1	2
Cravings for coffee, tea, cola	0	1	2		Eat fatty food	0	1	2
Cravings for fatty foods	0	1	2		Eat food that is not organically grown	0	1	2
Cravings for salt	0	1	2		Eat less than 4 servings of grain a day	0	1	2
Cravings for spicy foods	0	1	2		Eat less than 3 servings of fresh fruit a day	0	1	2
Cravings for sweets, fruit	0	1	2		Eat less than 2 servings of dairy products a day	0	1	2
Cravings for vinegar, ketchup	0	1	2		Eat less than 2 servings of fresh, dark-colored, vegetables a day	0	1	2
Other cravings—type?	0	1	2		Eat more thank 6 oz of protein a day	0	1	2
Distress eating fatty foods	0	1	2		Eat white bread	0	1	2
Drink carbonated beverages	0	1	2		Excessive fatigue during workouts	0	1	2
Drink fluoridated water	0	1	2		Eat meat (vegetarian or vegan)	0	1	2
Eat commercially raised meat	0	1	2		Excessive wrinkling of the skin/premature aging	0	1	2
Eat cooked and/or processed food	0	1	2		Food allergy, proven or suspected	0	1	2
Eat rapidly, without chewing thoroughly	0	1	2		Graying of the hair	0	1	2
Eat until you feel full	0	1	2		Have a small appetite	0	1	2
Emotional or stress eater	0	1	2		Have stress in your life	0	1	2
Feel a need to eliminate too soon after eating	0	1	2		High fat diet	0	1	2
Feel flush after eating	0	1	2		Hungry soon after meal	0	1	2
Feel sleepy or have low energy after eating	0	1	2		Hyperactivity or excessive nervousness without food	0	1	2
Feel too full after eating	0	1	2		Muscles feel weak after performing daily activities	0	1	2
Food passes through undigested	0	1	2		Persistent cramps	0	1	2
Foreign travel in the last 90 days	0	1	2		Poor smell / taste	0	1	2
Get indigestion after eating	0	1	2		Pulse speeds after meals	0	1	2
Have diarrhea after eating	0	1	2		Sleepy after meals	0	1	2
Have difficulty breathing after eating	0	1	2		Take vitamins	0	1	2
Have uncomfortable or adverse reactions after eating	0	1	2		Trouble sleeping	0	1	2
History of food poisoning	0	1	2		Unpleasant taste in mouth	0	1	2
Low carbohydrate diet	0	1	2		Weakness or faintness between meals	0	1	2
Low energy	0	1	2		Weight gain	0	1	2
Low fiber diet	0	1	2		Weight loss	0	1	2
Undergone surgery in the last 90 days	0	1	2		Would you like to work with our nutritionist	0	1	2
Practice mindful eating (No distractions, e.g. TV or work)	0	1	2		Other			
Read nutritional labels	0	1	2					

Physician Notes: _____

_____

_____

Physician Signature: _____ Date: _____