Please complete the following questionnaire as thoroughly as possible. This will be a part of your confidential medical record and will be released ONLY with your written authorization and permission.
DATE_____

LAST NAME_____ FIRST NAME_____ MIDDLE INITAL _____
DATE OF BIRTH _____ AGE _____GENDER (SEX) _____
ADDRESS _____ CITY/STATE_____ ZIP_____
HOME PHONE _____ CELL PHONE_____WORK PHONE_____
EMAIL_____

SINGLE_____MARRIED_____DOMESTIC PARTNER_____ DIVORCED/SEPARATED_____ WIDOWED_____
CHIILDREN? Y/N IF YES, LIST NAME/AGE_____
OCCUPATION _____ EMPLOYER_____
If Retired, previous occupation: _____ # of years_____
INSURANCE COMPANY _____ INSURANCE ID #_____
(Note: Payment for all co-pays, co-insurance, deductibles, services and products are expected at time of service. Please contact your insurance company to verify coverage. All payments are due at time of service for office visit charges and nutritional supplements, which are not covered by insurances.)

PRIMARY CARE DOCTOR(if any):_____ Date last seen_____
Reason for being seen:_____ Office Name_____
Doctor's phone number:_____ Doctor's full address: _____

Current Provider(s) NAME:	For what health reason	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please List Your Health Concerns in order of importance:
1._____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICAL/HEALTH HISTORY

If you have ever had any of the following, please check below. *Indicate approximate date of onset*

_____ AIDS/HIV Infection	_____Frequent Antibiotic Use	_____ Migraine Headaches
_____ Allergies	_____Freq Steroid Use/Prednisone	_____ Mononucleosis
_____ Anemia	_____Gallbladder Disease	_____ Mumps
_____ Appendicitis	_____German measles	_____ Nervous Breakdown
_____ Arthritis	_____Giardia/Parasites	_____ Neurological Disorder
_____ Asthma	_____Glaucoma	_____ Exposure/Toxic Substs
_____ Attempted Suicide	_____Gout	_____ Prostatitis
_____ Bursitis	_____Hay fever	_____ Psoriasis
_____ Cancer	_____Heart Disease	_____ Rheumatic Fever
_____ Cataracts	_____Hepatitis	_____ Scarlet Fever/Scarlatina
_____ Chickenpox	_____Herpes	_____ Seizure Disorder
_____ Chronic Fatigue Syn	_____High Blood Pressure	_____ Sexually Transmi Disease
_____ Chronic Ear Infect	_____Hives	chlamydia/warts/herpes/syphilis
_____ Colitis/Crohn's Dz	_____Hypoglycemia	_____ Sleep apnea
_____ Depression	_____Jaundice	_____ Stroke

_____ Diabetes (Type I or II) _____ Kidney Infections _____ Substance Abuse/Addiction
_____ Eating Disorder _____ Kidney Stones _____ Thyroid Disease
_____ Eczema _____ Liver Disease _____ TIA's (mini-strokes)
_____ Edema (Fluid Retention) _____ Low Blood Pressure _____ Tuberculosis (TB)
_____ Emphysema _____ Lyme Disease _____ Vaccine Reaction
_____ Fibromyalgia _____ Measles _____ Whooping Cough
_____ Chronic Back problems _____ Heart Murmur _____ Phlebitis
_____ Chronic Vaginitis _____ Hemorrhoids _____ Polio
_____ Chronic Sinus Infections _____ Head injury _____ Ulcers
_____ Chronic Bladder Infections _____ Last Tetanus Booster _____ Warts
Other:_____

SKIN Dry _____ Oily _____ Itching _____ Rashes _____ Hives _____ Flush Easily _____
Fungal Infections _____ Bruise Easily _____ Slow Healing _____
Warts _____ Moles_____ Where? _____ How Many? _____
Nails: Soft_____ Break_____ Do you bite your nails (finger/toes) Yes ___ No____
HEAD TMJ _____ Dizziness _____ Fainting _____ Seizures _____
Migraines_____ Headaches_____ Location of pain_____ *Worse*: Light ___ Noise____ Odors_____
Head Injury _____ Describe_____
EYES Vision Disturbance _____ Dryness_____ Tearing_____ Pain _____ Styes _____
Infections _____ Sensitive to Light _____ Floaters _____ Corrective lenses _____
EARS Discharge _____ Pain_____ Itch_____ Impaired Hearing _____Wax build up_____
Ringing _____ -Intermittent____Constant_____
NOSE Seasonal Allergies _____ Drainage _____ *Color:* Clear___ Yellow___ Green___
Texture: Runny_____ Thick_____ Post Nasal Drip _____ Clear Throat Often_____ Snoring _____
Stuffiness _____ Sneezing _____ Sinus Infections _____ Nosebleeds _____ Polyps_____
THROAT/NECK Pain in Throat _____ Enlarged Glands _____ Difficult Swallowing _____
Voice Changes _____ Hoarse Voice_____ Clear Throat Often _____ Recurrent Strep Infections_____
MOUTH Dryness_____ Excessive Salivation_____ Multiply Cavities _____ *Tongue:* Sore___ Coated___
Canker Sores _____ Fever Blisters _____
RESPIRATORY Frequent Colds/Infections_____ Asthma ____ Wheezing_____ Shortness of Breath____
*Cough*_____-Chronic_____-Productive (w/ mucus)_____ -Spit up Blood _____ Bronchitis _____
Pneumonia _____ - How many times:_____ - R_____ L_____ Positive TB Test (Ever) _____
CARDIOVASCULAR Chest Pain _____ Heart Palpitations/Racing_____ Heart Disease _____
Heart Murmur _____ High___ Low___ Blood Pressure; Varicose Veins _____ Phlebitis _____
Leg Pains _____ Cramps_____ Ankle Swelling _____ Cold Hands_____ Cold Feet_____
High Cholesterol_____ High Triglycerides_____
DIGESTION Bowel Movement ____ per day: 1-2____ 2-3____ 3-4____ OR per week: 1-2____ 2-3____ 3-4____
Size: Sm___ Med___ Lg___ *Color*: Brown___ Tan___ Rust___ *Texture*: Dry___ Hard___ Wet/Loose___
Pellets___ *Stool with*: Mucous____ Blood____ *Hemorrhoids* _____ -Bleeding____ Painful____ -Itching____
Fissures/Fistulas _____ Stool Incontinence _____ Bowel Disease _____
Liver/Gallbladder Disease _____ Ulcer _____ Heartburn _____ Bloating _____ Belching _____
Gas/Flatus _____ Nausea/Vomiting _____ Pains/Cramps _____
URINARY Difficult Urination _____ Painful Urination _____ Incontinence/Dribbling _____ Blood in
Urine _____ Bedwetting _____ Frequent Urination : - Day _____ Night _____
Frequent Bladder Infections_____

SLEEP How many hours? _____ Difficulty Falling Asleep Yes/No Restlessness_____
Frequent waking _____ -time: 12-1am____ 1-2 am_____ 3-4am_____ 4-5am_____ Wake Refreshed? Yes/No
Stick feet out of covers Y/N Wake Grumpy? Y/N Snore Y/N Talk Y/N Grind Teeth Y/N Sleepwalk Y/N
Hot_____ Cold _____in bed Nightmares Y/N Dream a lot Y/N Sleeping position._____
APPETITE Excessive____ Average____ Poor____ Foods you crave _____
. Foods you dislike _____
Recent Weight Change Y/N Recent appetite change Y/N Recent change in thirst Y/N
Prefer foods Hot_____Warm_____Cold____ *Thirst*: -Excessive ____ Avg_____Poor____
Prefer drinks Very Hot_____ Hot_____ Warm____ Room temperature _____ Cold_____ Ice cold_____
MUSCULO-SKELETAL Back Pain_____ Pain in Muscles_____ Pain in Joints _____ Shooting Pain _____
Pain in Bones_____ Stiffness/Swelling _____ Muscle Weak/Tremor _____ Numbness/Tingling _____
Paralysis _____ Is one side Worse? R_____ L_____
Ever Broken Bones? _____Where_____Ever Sprain Joints? _____ Where_____

WOMEN ONLY
Date of Last Period_____Last Pelvic Exam _____Date/Results of Last Pap Smear _____ Abnormal Pap _____
Age Period Began _____ Regular Periods Yes__ No__ Days of Menstrual Flow _____ Length of Cycle _____
Flow: Heavy___ Medium___ Light___ Spotting _____ Cramps_____ PMS_____
Yeast Infections ____ Vaginal Discharge ____Endometriosis_____ PID____ Fibroids_____Ovarian Cysts_____
DES Exposure _____ Sexually Transmitted Disease _____ History of Sexual Abuse _____
Ever Used Birth Control Pills? ____How Long For?_____How Long Ago?_____ Present Birth Control_____
Change in Sex Drive _____ Painful Intercourse _____
Pregnancies (number) _____ Childbirth (number)_____
Complications _____ Miscarriages (number)_____
Abortions (number)_____ Impaired Fertility _____
Age at Menopause _____ Had Hysterectomy? _____ Vaginal Dryness _____ Hot Flashes _____
Do You Do Self Breast Exams? _____ Mammograms (number) _____ Date of Last Mammogram _____

MEN ONLY
Date of Last Prostate Exam _____ Prostate Enlargement _____
Change in Force of Urine Stream _____ Difficulty Starting Urine _____
Do you do Self Testicular Exam _____ History of Undescended Testes _____
Pain / Lump in Scrotum _____ Discharge From Penis _____ Painful Intercourse _____
Difficulty with Erections _____ Change in Sex Drive _____ Impaired Fertility _____
Sexually Transmitted Diseases _____ History of Sexual Abuse _____

PAST MEDICAL/HEALTH HISTORY: Hospitalization(s): _____
_____
_____
Serious Illnesses &/or Injuries: _____
_____
Date of Last Physical_____ Date of Last Blood Tests_____
Date of Last Colonoscopy_____ Date of Last DEXA (bone density test)_____

FAMILY HISTORY: **Please indicate: S=Self M=Mother F=Father S=Sister B=Brother G=Grandparents C=Children SP=Spouse O=Other**

CONDITION	***YES***	***RELATION***	***PAST (P) NOW (N)***	***CONDITION***	***YES***	***RELATION***	***PAST (P) NOW (N)***
Addiction (alcohol/drug)				Kidney Disease			
				Learning Disabled			
Allergies				Mental Illness			
Alzheimer's				Migraines			
Arthritis				Parkinson's			
Asthma				Psoriasis			
Birth Defects				Seizure			
Blood disorders				Skin Disorder			
Depression				Stroke			
Diabetes				Suicide			
Eczema				Thalassemia			
Epilepsy				Thyroid disorder			
Glaucoma				Tuberculosis			
Heart Attack				Cancer: Breast			
Heart Disease				Colon			
Hepatitis				Lung			
Hemophilia				Prostate			
High Cholesterol				Skin			
Hypertension				Other			

OTHER:

Please list all prescription & over the counter medications that you are currently taking:

Medication	Dose	Date Started	Prescribed By

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking:

Supplement	Dose	Date Started

Please list any severe / life-threatening *allergies* (drugs, food, other):

Please Explain

PERSONAL HABITS Please indicate which substances, if any, pertain to you **N= use NOW P= used in PAST**

SUBSTANCE	**N / P**	**How Much?**	**How Long?**	**SUBSTANCE**	**N / P**	**How Much?**	**How Long?**
Tobacco				Soda			
Coffee				Alcohol			
Black Tea				IV Drug Use			
Artificial Sweeteners				Recreational Drug			

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Do you have any dietary restrictions/OR follow a particular dietary regimen? If yes, please describe:

_____

_____

ONLY Number the foods you CRAVE: *3= Very Strong 2 =Strong 1= Medium* Sweets_____ Chocolate_____
Salt_____ Sour_____ Hot/Spicy_____ Meats_____ Milk_____ Cheese_____ Fats_____ Eggs_____
Butter_____ Vinegar_____ Lemons_____ Pickles_____ Coffee_____ Alcohol_____Other_____
ONLY Number the foods you DISLIKE : *3= Very Strong 2 =Strong 1= Medium*
Oysters_____ Onions_____ Eggs_____ Milk_____ Other_____
List foods that cause digestive discomfort: 1._____2._____3._____
List symptoms after eating above foods: 1._____2._____3._____
ENERGY What is your general level of energy, scale from 1-10 (10 is optimal/best) _____
Does it change throughout the day? Y/N Best time of day _____ Worst time of day_____
Energy level after exercise : Better _____ Worse ____
PERSPIRATION Sweat Easily Y/N Sweat Excessively Y/ N Sweat Very Little Y/N During the night Y/N
TEMPERATURE Do you tend to feel Hot or Cold? *Sensitive to*: Hot____ Cold____ Both_____
Prefer: Inside___ Outside___ Best Season_____ Worst Season_____
MENTAL/EMOTIONAL List adjectives that best describe you:
1._____ 2._____ 3._____
4._____ 5._____ 6._____
Mark emotions often felt: Joy____ Anger_____ Fear_____ Anxiety____ Sadness_____
Do you experience mood swings? Y/N Do you cry easily? Y/N Have you ever lost a loved one? Y/N
Do you like to be consoled? Y/N
Mark phobias (if any*): 3=Very strong 2= Strong 1= Medium* Heights_____ Bridges_____
Crowds_____ Water_____ Claustrophobia _____ Dark_____ Spiders_____ Being alone_____
Public speaking_____ Flying_____ Thunderstorms____ Other_____
Any issues with memory _____ Mental Clarity_____ Focus/Attention_____
Do you exercise regularly? Yes/No What type? _____
Do you have a specific spiritual practice? Y/N If so, please describe it _____

EMERGENCY CONTACT: (Name) _____
. (Address)_____ (Phone) _____
Please contact your insurance company to verify coverage. Submission of co-pay is not confirmation of insurance reimbursement; as your insurance company processes claims and notifies us of any patient balance, you will be billed accordingly. All payments are due at time of service for office visit charges and nutritional supplements that are not covered by insurances. A $25 return check fee will apply to all returned checks.

****CANCELLATIONS (without a 24-hour notice) AND MISSED APPOINTMENTS ARE SUBJECT TO A $50.00 CHARGE ****

I understand and agree to the above criteria.
Signature_____Date_____

If patient is under 18 years old: I hereby authorize medical treatment for my child from the office of Sherry L. Stemper, N.D. I understand I have the responsibility of my child's healthcare, and have legal control of their medical records until the age of 18.

Guardian's Name (print) _____Signature of guardian _____