HIGH DESERT NATUROPATHIC CARE
Deborah M. Anderson Keller, ND, LM
404 Brunn School Rd., Bldg. C, Santa Fe, NM 87505
Tel: 505/670-9042

CONFIDENTIAL PATIENT INFORMATION (ADULT)
DATE:_____

Patient's Name:_____ Age:_____ Sex:_____ Birth date:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone (home):_____ (work):_____ E-mail:_____

Do you give Dr. Anderson Keller permission to leave a confidential voice message?

Yes _____ No _____ Preferred Number for Message: _____

Occupation:_____ Employer or School:_____

Marital Status:_____ Social Security #: _____

Person to be contacted in case of Emergency:_____ Relationship:_____

Address:_____ Phone:_____

Your Primary Care Physician or person you see regularly for health care:_____

How did you hear about Dr. Anderson Keller?_____

PLEASE LIST THE HEALTH CONCERNS THAT BRING YOU IN TODAY

1.
2.
3.

Are you willing to change your lifestyle habits to improve your health? YES _____ NO_____

MEDICATIONS

	now	past	frequency
Pain Relievers (List types used)	____	____	_____
Antibiotics	____	____	_____
Decongestants	____	____	_____
Laxatives	____	____	_____
Thyroid	____	____	_____
Blood Pressure	____	____	_____
Antidepressants	____	____	_____
All Other (please list)	____	____	_____

Please list all vitamins, herbs, homeopathic, or other supplements that you are taking:_____

_____

ALLERGIES (to medications, supplements, foods, or environment)_____

_____

PAST SURGERIES/HOSPITALIZATIONS - Please list dates and reason for any surgeries or hospitalizations:

_____

_____

_____

_____

HEALTH HISTORY

Please put an **N** if you have the condition now; **P** for in the past; **B** for both:

___ Measles	___ Scarlet Fever	___ Angina
___ Mumps	___ Rheumatism	___ Heart Murmur
___ Influenza	___ Bronchitis	___ Fatigue
___ Mononucleosis	___ Herpes (oral)	___ Muscle Weakness
___ Hay Fever	___ Herpes (genital)	___ Diarrhea
___ Headaches	___ Shingles	___ Constipation
___ Dizziness	___ Gonorrhea	___ Cough/Wheezing
___ Hives	___ Insomnia	___ Indigestion/Gas
___ Pneumonia	___ Jaundice	___ Anxiety
___ Colitis	___ Ringing in the Ears	___ Backaches
___ Joint Pain	___ Bladder Infection	___ Strep Throat
___ Frequent Infections	___ Memory Loss	___ Moodiness

FAMILY HISTORY

Please check Self if you have had any of the following. Also, please identify any family member(s) that have had any of the following:

	Self	Family Member(s)
Allergies	___	_____
Alcoholism	___	_____
Asthma	___	_____
Autoimmune Disorder	___	_____
Bleeding Disorder	___	_____
Cancer	___	_____
Diabetes	___	_____
Epilepsy	___	_____
Heart Disease	___	_____

HEALTH & LIFESTYLE HABITS

Do you use tobacco? _____ If yes, how much per day? _____ For how long? _____
How often do you drink wine? _____ beer? _____ other alcohol? _____
How often do you drink coffee? _____ How often do you drink soda pop? _____
Diet restrictions? _____
How often do you exercise? _____ Form(s) of exercise _____
List any chemicals, fumes, dust, etc. that you are repeatedly exposed to: _____
_____