



The Center for Natural Cures

New Patient Information

Democracy Medical Center, 6318 Democracy Boulevard, Bethesda, MD 20817
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First Name _____ Last Name _____ Date _____

Age _____ Date of Birth _____ Place of Birth _____ F ____ M ____

Address _____

City _____ State _____ Zip _____

Occupation _____ Employer _____

Phone: Home _____ Work _____ Cell _____

Email _____

Referral Source _____

Emergency Contact _____ Relationship _____ Phone _____

Main Complaint _____

How long have you had the problem _____ Event(s) leading to the problem _____

What diagnosis have you been given _____

What have done to help the problem

What is the results

Other Complaints _____

How long have you had them

What have you done to help them

What results _____

Current Medications _____

Allergies you know about _____

Surgeries and Hospitalizations _____

History of illness and how long you have had it:

| | | | | | |
|-------------------|--|-----------------|--|--------------------|--|
| ADHD/Autism | | Anemia | | Anxiety/Depression | |
| Arthritis | | Asthma | | Cancer | |
| Colitis/Gastritis | | Diabetes | | Eczema | |
| Endometriosis | | Fibroid/Cysts | | High/Low BP | |
| Heart Disease | | Liver Disease | | Lung Disease | |
| Kidney Disease | | Thyroid Disease | | Other | |

Have you had any physical injuries (such as car accident)? _____ When? _____

Medication History:

Were you vaccinated as a child? _____ Any reactions? _____ To which one? _____

How many vaccines have you had in the past 5 years? _____ Last vaccination (including flu shots)? _____

Have you used antibiotics frequently (including childhood)? _____ What for? _____

Have you used birth control pills/patches? _____ When? _____ For how long? _____

Have you used hormone replacement therapy? _____ When? _____ For how long? _____

List your supplements _____

Dental History:

How many amalgams (silver/mercury fillings) do you have? _____ How long have you had them? _____

Have they been replaced? _____ How many? _____ When? _____ By who? _____

Have you had tooth extractions? Wisdom teeth _____ Other teeth _____ When? _____

How many root canals have you had? _____ Which ones? _____ When? _____

Other dental works: Crowns _____ Bridges _____ Implants _____ Surgery _____

Do you have pain, swelling or bleeding in your mouth? _____ For how long? _____

Environmental Survey:

Do you live (have you lived) near a river/lake/pond _____ golf court _____ factory _____ power plant _____
chemical plant _____ power line _____ radio/cell phone tower _____? For how long? _____

Are you often exposed to chemicals and other toxic materials at home or work? _____

Paints _____ Solvents _____ New carpets/furniture _____ Pesticides _____ other _____

How old is your house? _____ When was the last time you had the air duct cleaned? _____

Do you notice any presence of mold at home or place of work? _____

Life Style Survey:

Do you use the following? How much a day? Alcohol (cups)_____ Coffee (cups)_____ Soft drink (cans)_____

Cigarette (packs) _____ Drugs _____ How much water do you drink a day? _____(8 oz glass)

Do you exercise?_____ How many times a week?_____ What kinds? _____

List five foods and snacks you eat most often (in the order of frequency):

How often do you eat sugary foods/snacks (cookies, soft drinks, etc)?_____

How often do you eat flour products (bread, pasta, crackers, etc)? _____

How often do you eat dairy products? _____ Soy products? _____

What types of oils and fats do you use? _____

What types of protein do you eat? _____

How often do you eat fish? _____ What kinds? _____

How often do you eat fresh vegetables and fruits?_____

Do you have regular bowl movement (at least once a day)? _____

Symptom Survey: (grade on the scale of 1-5. 1=mild, 5=severe)

| | | | |
|---------------------------------------|--|----------------------------------|--|
| Constipation | | Coughing or wheezing | |
| Loose stool or diarrhea | | Sinus congestion or runny nose | |
| Bloated or gassy | | Itchy or watery eyes | |
| Food craving (sugar, fat, salt) | | Frequent colds or ear infections | |
| Stomach or abdominal pain | | Shortness of breath | |
| Poor appetite | | Heart palpitation | |
| Heartburn/reflex | | Foggy/memory loss | |
| Itchy or dry skin | | Mood swings/Depression | |
| Hair loss or brittle nail | | Frequent yeast infections | |
| Fatigue (morning, afternoon or night) | | Low sex drive or impotence | |
| Dizziness | | Difficulty of gaining weight | |
| Sleep problem | | Difficulty of losing weight | |
| Painful, stiff or swollen joint | | Cold or hot body temperature | |
| Muscle cramping | | Numbness or tingling | |
| Headache or migraine | | Frequent/difficult urination | |
| Other | | | |