



Janene Martin, ND

410.433.4005
410.433.0909 fax

5801 Falls Road
Baltimore, MD 21209

Personal Information (Adult)

Date _____
TODAY'S DATE

Patient's Name _____
FIRST MIDDLE LAST

Address _____
CITY STATE ZIP CODE

Phone Numbers _____
 HOME WORK CELL/MOBILE

Please **check box** to indicate preferred number for appointment reminders and messages.
No health information will be disclosed.

Information _____
DATE OF BIRTH

_____ AGE Gender MALE FEMALE OTHER

Employment Info _____
EMPLOYER NAME HOURS PER WEEK

Marital Status Single Married Partnership Separated Divorced Widowed

With whom do you live? Spouse Partner Parents Friends Children Alone

Spouse Name _____
FIRST LAST DATE OF BIRTH

Spouse Address _____
STREET ADDRESS / CITY / STATE / ZIP CODE

Spouse Phone _____
MAIN CONTACT NO.



Janene Martin, ND

410.433.4005
410.433.0909 fax

5801 Falls Road
Baltimore, MD 21209

Personal Information (Adult) — *continued*

Emergency Contact _____
NAME

Relationship _____ Telephone Phone _____
RELATIONSHIP TO PATIENT CONTACT PHONE

If someone other than patient is responsible for payment, please complete the following.

Name of Responsible Party _____
NAME

Relationship _____ Telephone Phone _____
RELATIONSHIP TO PATIENT CONTACT PHONE

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Dr. Janene Martin to release information necessary to secure payment.

Authorization _____
SIGNATURE DATE

How did you learn about Dr. Janene Martin? _____

May I thank the person who referred you? YES NO



Janene Martin, ND

410.433.4005

410.433.0909 fax

5801 Falls Road
Baltimore, MD 21209

Medical History

In order for me to best serve your health care needs I need to completely understand your physical, mental, and emotional conditions. The information you provide helps me understand your needs and how to help you reach your health goals. Please write legibly and answer all questions thoroughly. Feel free to mark anything you may have a question about.

When did you last visit a doctor's office, medical clinic or hospital? Please explain.

Please list your chief health concerns and/or symptoms, and for how long they have been present.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

What would you like to accomplish on your initial visit?

Are you aware of any allergies to food, drugs or other environmental allergens (cats, mold, dust, etc.) If yes, please list and explain (type of reaction, how quickly you react, have you noticed reaction worsening, frequency of exposure(s), etc.)

What hospitalizations or surgeries have you had?



Janene Martin, ND

410.433.4005

410.433.0909 fax

5801 Falls Road
Baltimore, MD 21209

Personal Information (Adult) — *continued*

Family History

Do you have a family history of any of the following?

- | | | |
|----------------------------------------------|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hayfever/hives | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Liver disease | |

Is your father still living?

- Yes, his age _____ health status _____
- No, age at death _____ cause of death _____

Is your mother still living?

- Yes, her age _____ health status _____
- No, age at death _____ cause of death _____

Siblings still living?

- Yes, age _____ health status _____
- No, age at death _____ cause of death _____
- Yes, age _____ health status _____
- No, age at death _____ cause of death _____
- Yes, age _____ health status _____
- No, age at death _____ cause of death _____



Janene Martin, ND

410.433.4005
410.433.0909 fax

5801 Falls Road
Baltimore, MD 21209

Personal Information (Adult) — *continued*

Children still living?

- Yes, age _____ health status _____
- No, age at death _____ cause of death _____
- Yes, age _____ health status _____
- No, age at death _____ cause of death _____
- Yes, age _____ health status _____
- No, age at death _____ cause of death _____
- Yes, age _____ health status _____
- No, age at death _____ cause of death _____

Childhood Illnesses

Please check whether you have/had any of the following conditions as a child/adolescent:

- Diphtheria
- Mumps
- Measles
- German measles
- Rheumatic fever
- Other _____

Past Immunizations

Please check whether you have/had any of the following immunizations. If unsure, please write a question mark beside the immunization:

- Diphtheria
- Polio
- Pertusis
- Measles/Mumps/Rubella
- Tetanus
- Other _____



Janene Martin, ND

410.433.4005

410.433.0909 fax

5801 Falls Road
Baltimore, MD 21209

Review of Systems

Please check: Y = Yes, present condition N = No, never had condition P = Past condition

Head

Headaches Y N P

Head injury Y N P

Migraine headaches Y N P

Jaw/TMJ problems Y N P

Ears

Ringings Y N P

Earaches Y N P

Dizziness Y N P

Impaired hearing Y N P

Neck

Lumps Y N P

Goiter Y N P

Swollen glands Y N P

Pain or stiffness Y N P

Skin

Rashes Y N P

Lumps Y N P

Itching Y N P

Thinning of hair Y N P

Psoriasis Y N P

Acne, boils Y N P

Loss of hair Y N P

Balding/Alopecia Y N P

Eczema, hives Y N P

Color changes Y N P

Skin – *continued*

Night Y N P

Hirsutism Y N P

Musculoskeletal

Joint pain Y N P

Arthritis Y N P

Muscle spasm Y N P

Broken bones Y N P

Weakness Y N P

Sciatica Y N P

Eyes

Blurred vision Y N P

Eye pain/strain Y N P

Spots in vision Y N P

Cataracts Y N P

Glaucoma Y N P

Color blindness Y N P

Glasses/contacts Y N P

Tearing/dryness Y N P

Double vision Y N P

Nose/Sinuses

Stuffiness Y N P

Hayfever Y N P

Loss of smell Y N P

Nose bleeds Y N P

Sinus problems Y N P

Frequent colds Y N P



Janene Martin, ND

410.433.4005
410.433.0909 fax

5801 Falls Road
Baltimore, MD 21209

Please check:

Y = Yes, present condition
N = No, never had condition
P = Past condition

Mouth/Throat

- Hoarseness Y N P
- Jaw clicks Y N P
- Gum problems Y N P
- Dental cavities Y N P
- Frequent sore throat Y N P
- Sore lips/tongue Y N P

When was your last dental visit? _____

Respiratory

- Asthma Y N P
- Bronchitis Y N P
- Cough Y N P
- Difficulty breathing Y N P
- Emphysema Y N P
- Pain with breathing Y N P
- Pleurisy Y N P
- Pneumonia Y N P
- Shortness of breath (SOB) Y N P
- SOB at night Y N P
- SOB lying down Y N P
- Spitting up blood Y N P
- Sputum Y N P
- Tuberculosis Y N P
- Wheezing Y N P

Cardiovascular

- Angina Y N P
- Murmur Y N P
- Fainting Y N P
- Palpitations Y N P

Cardiovascular – continued

- Chest pain Y N P
- Heart disease Y N P
- Ankle swelling Y N P
- Fluttering Y N P
- Blood clots Y N P
- Rheumatic fever Y N P
- Low/high blood pressure Y N P

Gastrointestinal

- Diarrhea Y N P
- Ulcer Y N P
- Jaundice Y N P
- Heartburn Y N P
- Liver disease Y N P
- Trouble swallowing Y N P
- Constipation Y N P
- Black stools Y N P
- Hemorrhoids Y N P
- Abdominal pain Y N P
- Nausea Y N P
- Belching/gas Y N P
- Change in thirst Y N P
- Coughing up blood Y N P
- Gall bladder disease Y N P
- Blood in stool Y N P
- Vomiting Y N P
- Bloating Y N P

How many bowel movements per day? _____

Is this a change? _____



Janene Martin, ND

410.433.4005

410.433.0909 fax

Please check:

Y = Yes, present condition

N = No, never had condition

P = Past condition

5801 Falls Road

Baltimore, MD 21209

Urinary

- Incontinence Y N P
- Kidney stones Y N P
- Kidney disease Y N P
- Frequent infections Y N P
- Frequency at night Y N P
- Painful urination Y N P
- Increased frequency Y N P

Blood/Peripheral Vascular

- Anemia Y N P
- Leg pain Y N P
- Easy bleeding Y N P
- Cold hands/feet Y N P
- Easy bruising Y N P
- Thrombophlebitis Y N P
- Varicose veins Y N P

Neurological

- Fainting Y N P
- Seizures Y N P
- Paralysis Y N P
- Loss of memory Y N P
- Numbness/tingling Y N P
- Muscular weakness Y N P

Emotional

- Mood swings Y N P
- Anxiety Y N P
- Sense of doom Y N P
- Nervousness Y N P
- Depression Y N P

Emotional – continued

- Tension/stressed Y N P
- Panic attacks Y N P

Endocrine

- Hypothyroid Y N P
- Hyperthyroid Y N P
- Excessive thirst Y N P
- Excessive hunger Y N P
- Cold intolerance Y N P
- Heat intolerance Y N P

Male Reproductive

- Hernias Y N P
- Prostate issues Y N P
- Venereal disease Y N P
- Testicular masses Y N P
- Sexual difficulty Y N P
- Premature ejaculation Y N P
- Discharge or sores Y N P
- Testicular pain Y N P
- Fertility issues Y N P

Female Reproductive

- Painful menses Y N P
- Excessive flow Y N P
- Breasts tender Y N P
- Sexually active Y N P
- Sexual difficulty Y N P
- Breast lump(s) Y N P
- Endometriosis Y N P



Janene Martin, ND

410.433.4005
410.433.0909 fax

5801 Falls Road
Baltimore, MD 21209

Please check:

Y = Yes, present condition
N = No, never had condition
P = Past condition

Female Reproductive

Fertility issues	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P	Ovarian cysts	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Venereal disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P	Cervical dysplasia	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Regular cycles	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P	Bleeding between cycles	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Abnormal pap	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P	Menopausal symptoms	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
Nipple discharge	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P	PMS	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P
				Perform self breast exams	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> P

Age of first menses _____
AGE

Age of last menses (if menopausal) _____
AGE

Length of cycle _____
NO. DAYS BETWEEN

Duration of menses _____
NUMBER OF DAYS

Date of last female annual exam _____
MONTH/YEAR

Birth Control Y N P

If yes, what type? _____
TYPE/BRAND

Pregnancies _____
NUMBER

Live births _____
NUMBER

Miscarriages _____
NUMBER

Abortions _____
NUMBER

Difficulty conceiving Y N P

Sexual Preference Heterosexual Homosexual Bisexual

Daily Habits

Exercise Y N P

Use alcohol Y N P

Use recreational drugs Y N P

Sleep well Y N P

Use tobacco Y N P

Awaken rested? Y N P

If yes, what form? _____

Average 7 hours of sleep? Y N P

How often? _____



Janene Martin, ND

410.433.4005
410.433.0909 fax

5801 Falls Road
Baltimore, MD 21209

Please give an example of a typical days diet.

Breakfast _____

Lunch _____

Dinner _____

Beverages _____

Snacks _____

Is there anything else you would like me to know in order to serve you better?
