



Marcus Porrino, ND  
Rebecca H. Porrino, ND  
710 West Napa Street  
Sonoma, CA 94576  
707-996-9355

### PATIENTS HEALTH HISTORY

Female Name: \_\_\_\_\_  
First Middle Initial Last Preferred name

Male Name: \_\_\_\_\_  
First Middle Initial Last Preferred name

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Contact numbers: home \_\_\_\_\_ work/cell: \_\_\_\_\_

Preferred # for appointment reminders and other messages – no health information will be disclosed: \_\_\_\_\_

Female SS #: \_\_\_\_\_ Driver's license #: \_\_\_\_\_ Birth date: \_\_\_\_\_

Age: \_\_\_\_\_ Do you have any children yet you have: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Male SS #: \_\_\_\_\_ Driver's license #: \_\_\_\_\_ Birth date: \_\_\_\_\_

Age: \_\_\_\_\_ Do you have any children yet? Y N If so, how many: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Marital status:  Single  Married  Partnership  Separated  Divorced

With whom do you live  Alone  Together/Spouse  Separate  Parents  Friends  Children

Emergency contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone number: \_\_\_\_\_

If someone other than patients is responsible for payment, please complete the following:

Name of responsible party: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

In furnishing this information, I hereby grant consent for all treatments deemed necessary by the doctors of Sonoma Naturopathic Medicine for the purposes of wellness, prevention, or health care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

How did you hear about our clinic \_\_\_\_\_

Yes, please send me the quarterly newsletter: Email : \_\_\_\_\_



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## HEALTH HISTORY QUESTIONNAIRE

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Naturopathic healthcare is most effective when the doctor completely understands the patient's physical, mental, and emotional concerns and conditions. The information you provide helps me understand your needs and how to best help you reach your health goals. Your time, honesty, and thoughtfulness is appreciated. Feel free to mark anything you may have a question about.

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Why did you choose to come to this clinic? \_\_\_\_\_

Are you currently seeing a gynecologist, GP or other fertility specialist? Y N

Have you undergone any treatment for fertility so far? Y N P

Are you currently taking fertility medications? Y N Past

If yes, whom and for how long? \_\_\_\_\_

If no, when and where did you last receive medical or health care?

What was the reason? \_\_\_\_\_

What three expectations do you have from this visit to our clinic?

What expectations do you have of me as your doctor?

What is your present level of commitment to addressing the underlying causes of your infertility?  
(Rate from 0 to 10-- 0 being little commitment, 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or habits do you engage in regularly that you believe support your health?

What behaviors or habits do you engage in regularly that you believe do not support your health?



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What do you love to do?

**EXPOSURES**

	Female	Male
Current weight		
Recent weight-loss?		
Current height		
Occupation		
Mark with a Y or N in column	Female	Male
In the past 2 years, have you have frequent contact with chemicals including: solvents, paints, new carpets, new cars, manufacture of plastics, cooking in plastic, glues, insecticides, pesticides, frequent use of carbonless paper, hair colors or hair perming agents?		
Contact with heavy metals		
X-ray (dental or otherwise), MRI, or CAT scan (give dates if so)		
Use microwave		
Sleep near a fuse box		
Live or work near transmitter or power lines		
Often travel/commute during rush hour		
Currently, do you choose non-toxic personal care products (antipersirant, toothpaste, lotions, creams.) If yes, give brands.		
Exposure to second hand smoke? Past, currently?		
Do you buy organic food? If so, what percentage of food you eat is organic?> (Please consider eating out as well.)		
Do you wash your fruits and vegetables?		
Any known exposure to radiation or chemotherapy?		

Any family history of difficult conceiving? If so, who?

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**REPRODUCTIVE HEALTH:**

	Y	N
Have you already started trying to conceive? If yes, how long have you been trying? _____		
Have you had any prior conceptions? Male or Female --Please circle: live/ miscarriage/ stillborn/ termination/ premature/ small for dates/ or perinatal death		

--Give dates: _____		
--Past conceptions with current partner?		
Has your current partner been responsible for any conceptions other than those above?		
Were these conceptions with your current partner?		
Has your partner been responsible for other conceptions? If so, explain _____		

FEMALE REPRODUCTION/BREASTS

Age of first menses: \_\_\_\_\_  
 Length of cycle: \_\_\_\_\_ days  
 Duration of menses: \_\_\_\_\_ days  
 Are cycles regular Y P N

Bleeding between cycles Y P N  
 Date of last pap: \_\_\_\_\_  
 Abnormal PAP Y P N  
 Have you charted basal temperature Y N

	Y	P	N		Y	P	N
Ovarian cysts				Sexually transmitted disease			
Endometriosis				Herpes, warts			
Pelvic inflammatory disease				IUD			
PCOS				Menopausal symptoms			
Fibroids				Painful menses			
Yeast infections				Clotting during menses			
Bladder/Kidney infections				Heavy menstrual flow			
Abortion(s)				PMS			
Sexual difficulties				Pain during sex			
Nipple discharge				Unusual hair growth			
Recent weight gain				Difficulty losing weight			
Headaches/migraines				Breast discharge/leaking			
Used birth control pill							

MALE REPRODUCTION

	Y	P	N		Y	P	N
Hernia				Unusual discharge			
Testicular pain				Unusual sores			
Sexually transmitted disease				Difficulty urinating			
Impotence				Epididymitis			
Premature ejaculation				Semen analysis			
Testicular masses				Blood test for hormones			
Prostate disease				Thyroid tests			
Examination of testes				Undescended testes			



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Mumps				Use sauna, hot tubs often			
Style of underwear							

Style of underwear used: \_\_\_\_\_

Exercise: \_\_\_\_\_

**ALLERGIES**

Are you hypersensitive or <u>allergic</u> to:	Female	Male
Any medications		
Any foods:		
Other:		

**CURRENT MEDICATIONS**

Please ✓	Female	Male	Please ✓	Female	Male
Laxatives			Pain relievers		
Cortisone			Appetite suppressants		
Please ✓	Female	Male	Please ✓	Female	Male
Tranquilizers			Hormones		
Thyroid medication			Antacids		
Sleeping pills					

Please list ANY other prescription medications, over the counter medications, vitamins or other supplements you are taking: (Circle ♀=female partner, ♂=male partner)

- 1) ♀/♂ \_\_\_\_\_ 4) ♀/♂ \_\_\_\_\_
- 2) ♀/♂ \_\_\_\_\_ 5) ♀/♂ \_\_\_\_\_
- 3) ♀/♂ \_\_\_\_\_ 6) ♀/♂ \_\_\_\_\_

**HABITS (Y = now, P = past, N = never)**

Do you exercise? Y N If yes, what kind \_\_\_\_\_  
 How often \_\_\_\_\_

Spend time outside? Y N

How many hours of sleep do you get each night? \_\_\_\_\_

Sleep well	Y P N	Do you drink coffee	Y P N
Awaken rested	Y P N	Do you use tobacco	Y P N
Use recreational drugs	Y P N	Smoked previously	Y P N
Do you eat three meals a day	Y P N	Been treated for drug dependence	Y P N
Treated for alcoholism	Y P N	Use alcoholic beverages	Y P N
Do you go on diets often	Y P N	How often? _____	



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**REVIEW OF SYSTEMS**

Have either of you suffered form any of these conditions?

- a) Major disease conditions
  - Female
  - Male
- b) Mental emotional disease or neurologic? (Anxiety, mood, depression, tension...)
  - Female
  - Male
- c) Cardio vascular/Heart disease? includes high blood pressure, angina, heart attack, poor circulation palpitations
  - Female
  - Male
- d) Liver disease
  - Female
  - Male
- e) Immune system, Autoimmune conditions (includes thyroid, chronic infections/colds, slow healing, Diabetes,)
  - Female
  - Male

**DIGESTION:**

<b>Mark with a Y or N in column</b>	<b>Female</b>	<b>Male</b>
Do you have daily bowel movements? If not, who and how often? _____		
Do you experience diarrhea / gas /belching / blood in stools / regular heartburn / indigestion/bloating / bad breath		
Have you been diagnosed with Irritable bowel syndrome or disease?		
Do you have food cravings		
Do you suffer from headaches		
On a 1 to 10 scale, rate your stress level (10 is highest stress possible.		
Do you sleep well		
Do you wake rested		
In general, is you energy	HIGH/MED/LOW	HIGH/MED/LOW
What time of day is your energy the highest		
When is your energy the lowest		



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Are there any cultural or religious practices we should be aware of when providing healthcare to you? \_\_\_\_\_

Is there any information about your health you would like to add:

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Welcome and Congratulations on your decision to seek a different approach.  
We look forward to serving you.

Please return this intake form to:  
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710 West Napa Ave  
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FAX (707) 996-9356