Sarah Paton, ND
Naturopathic Doctor

Medical Information Form

Patient Name: _____ Date of Birth: _____

Current Concerns / Goals for Treatment:

_____
_____
_____
_____
_____
_____

Major Past/Present Illnesses, Dates and Treatments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Brief Family History: (Please indicate state of health, including current/past conditions. Please include the age of death if deceased.)

Father:_____
Mother:_____
_
Father's Mother:_____
Mother's Mother:_____
Father's Father:_____
Mother's Father:_____
Siblings:_____
_

All information is strictly confidential and will only be used by the office of Dr. Sarah Paton.

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Your Children:_____

Allergies to Medications, Foods, Animals, Environmental, Seasonal, etc
Please circle ONE:

Allergen: _____ Reaction: _____ Severity: Mild / Moderate / Severe
Allergen: _____ Reaction: _____ Severity: Mild / Moderate / Severe
Allergen: _____ Reaction: _____ Severity: Mild / Moderate / Severe
Allergen: _____ Reaction: _____ Severity: Mild / Moderate / Severe
Allergen: _____ Reaction: _____ Severity: Mild / Moderate / Severe

Medications and Supplements: (Please list including brand, dose and strength)

Name: **Strength/Dose:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any questions or concerns you specifically want to talk about?

_____
_____
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_____

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