



Identifying Data

Name: _____
Age: _____ Date of Birth: _____
Sex: M or F Marital Status: _____
Nationality / Race: _____
Number of Children: _____
Occupation: _____
Home Address: _____
City: _____
Province: _____ Postal Code: _____

Telephone # (home): _____
(work or cell): _____
E-mail address: _____
Emergency Contact: _____
Telephone #: _____
Family M.D.: _____
How did you hear about us/who referred you?

Care Card # _____

I am aware that all tests, procedures and prescriptions are my responsibility and must be paid for at the time services are rendered.

Signed: _____ Date: _____

What is your commitment level to being proactive in your health care? _____

Major Health Concerns (in order of priority) 1) _____
2) _____
3) _____

Has anything recently changed or become worse?

What questions do you have that you would like answered?

Were there any significant events that preceded the beginning of your chief concern? (e.g. accident, illness, surgery, stress, etc.)

Other practitioners you are currently seeing or have recently seen and treatments you are receiving.

Name	Type of Practitioner	Treatment
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

Family Medical History: Please list the current age and relevant medical problems. If deceased, list age and cause of death.

Mother: _____
Father: _____
Brothers: _____
Sisters: _____
Spouse: _____
Children: _____
Any Familial diseases: _____

Which childhood diseases have you had (please circle): Chicken pox mumps measles
whooping cough rheumatic or scarlet fever diphtheria polio other _____

As an infant were you breast fed? Yes or No
For how long? _____ (months)

Immunizations: complete or partial
Adverse reactions? _____

Past Surgeries: (circle and date)

Tonsils-	appendix-	gallbladder-
Hernia-	tubal ligation-	vasectomy-
Minor surgery-	back-	varicose veins-
Cosmetic-	skin lesions-	hysterectomy-
Prostate-	other-	

Past Hospitalizations: (date, reason & length of stay)

Past Medical Illness: (date & describe all major illnesses)

Dental History: (circle and date)

Silver amalgams/crowns _____
Gold amalgams/crowns _____
Dental implants _____
Wisdom teeth removed _____
Root canals _____
Dental appliances/bridges/dentures _____
What condition are your gums in? _____

Allergies and Drug Reactions: List and describe the reaction.

Drug: _____

Food: _____

Chemical: _____

Pollens/Molds: _____

Insects/Animals: _____

Current Medications: List ALL prescription, over the counter, health food store, multi-level marketed drugs, supplements, herbs etc. you take regularly and their dosage

Menstrual History:

Age of onset: _____ Date of last period: _____ Date of last PAP smear: _____

Was it normal? _____ Number of days between periods: _____

Duration of bleeding: _____

Amount of blood loss: _____ P.M.S. or cramps? _____

Would you say your period is regular? _____

List any past menstrual or gynecological problems: _____

Difficulty conceiving? _____ Number of pregnancies: _____

Number of deliveries: _____

Any birth complications? _____

Number of cesarean sections: _____

Number of miscarriages: _____ Number of abortions _____

Number of D & Cs: _____

Age at menopause _____ Menopausal symptoms: _____

Personal Profile / Social History

Dietary Habits: Briefly list what you eat and drink at a typical meal.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How do you rate your diet? Excellent good average poor terrible

Do you follow a specific diet? Yes or No

What kind? _____

Amount of water intake (daily) _____ What type? Tap bottled home filtered

Do you smoke? Yes or No How much per day? _____ Type _____

Recreational drug use: Yes or No Is this a concern for you? Yes or No

Alcohol use: daily several times per week weekend only occasional rarely never

Alcoholic beverage of choice _____ Amount consumed per use _____

Employment History: How many hours per day do you work? _____

Please briefly list all major jobs/ occupations in the past.

Education History: What is the highest level of education you have completed?

Travel history: Have you been out of the country recently? Yes or No

When? _____ For how long? _____

Where? _____

Are any of your health problems related to your travels? Yes or No

Marital History: Any major problems with your marriage/ common law partner? Yes or No

Any past divorces? Yes or No How Many? _____

Are you sexually active? Yes or No

Any sex-related concerns? Yes or No

Please briefly describe _____

General Health:

Do you exercise regularly? Yes or No

Type(s) _____

How often? _____

For how long? _____

Do you sleep through the night? Yes or No

of hours per night _____

Do you sleep well? Yes or No

Do you awaken feeling rested? Yes or No

Pets at home? Yes or No

How many? _____

What kind? _____

How long have you had them? _____

Where do they sleep? _____

Do you regularly relax, meditate, or pray?

Yes or No

What do you do for stress management?

Age of the home that you live in: _____

Is dust or mold a problem in your house?

Yes or No

Has there been any recent renovations done in

your home in the last 3 years? _____

Do you like your home and where you live?

Yes or No

Any financial difficulties? Yes or No

Recent or long term? _____

Present weight _____ (lbs) Height _____

Date of last physical _____

Maximum weight _____ (lbs) When? _____

Desired weight? _____ (lbs)

Review of Systems

Beside the following list, please indicate if it is a condition you have **now** by circling - **Y**. If it is a condition you have had in the **past**, but is okay now, circle - **P**. Circle -**N** if it is a condition you have **never** had. Record significant details in the margins.

General Body

Fatigue	Y	P	N
Fever	Y	P	N
Chills	Y	P	N
Night sweats	Y	P	N

Skin

Eczema / rash	Y	P	N
Psoriasis	Y	P	N
Acne, boils	Y	P	N
Hives	Y	P	N
Peculiar moles	Y	P	N
Lumps/ growths	Y	P	N
Bruising	Y	P	N
Pigmentation change	Y	P	N
Itch	Y	P	N
Infections	Y	P	N

Hair

Abnormal loss	Y	P	N
Change in texture	Y	P	N

Nails

Brittle	Y	P	N
Ridging	Y	P	N
Pitting	Y	P	N
Abnormal curvature	Y	P	N
Not growing	Y	P	N

Head

Stress headache	Y	P	N
Migraine headache	Y	P	N
Head injury	Y	P	N
Head pain	Y	P	N

Neck

Swollen glands	Y	P	N
Pain or stiffness	Y	P	N

Eyes

Impaired vision	Y	P	N
Double vision	Y	P	N
Cataracts	Y	P	N
Glaucoma	Y	P	N
Eye pain	Y	P	N
Discharge	Y	P	N
Tearing	Y	P	N
Dryness	Y	P	N
Redness	Y	P	N
Burning /itching	Y	P	N
Light sensitivity	Y	P	N
Blindness	Y	P	N
Glasses or contacts	Y	P	N

Ears

Impaired hearing	Y	P	N
ringing	Y	P	N

Dizziness	Y	P	N
Recurrent infections	Y	P	N
Discharge	Y	P	N
Earache/itch	Y	P	N

Nose / Sinuses

Impaired smell	Y	P	N
Nose bleeds	Y	P	N
Nasal / sinus congestion	Y	P	N
Runny nose	Y	P	N
Recurrent infection	Y	P	N
Post nasal drip	Y	P	N
Hayfever	Y	P	N

Mouth / Throat

Impaired taste	Y	P	N
Recurrent sore throat/ infections	Y	P	N
Gum disease	Y	P	N
Sore tongue	Y	P	N
Hoarsness / laryngitis	Y	P	N
Bad breath	Y	P	N
Canker sores	Y	P	N

Respiratory

Chronic cough	Y	P	N
Shortness of breathe	Y	P	N
Difficulty breathing	Y	P	N
Wheezing	Y	P	N
Blood in sputum	Y	P	N
Chest pain	Y	P	N
Recurrent pneumonia/bronchitis	Y	P	N
Asthma	Y	P	N
Emphysema	Y	P	N
Tuberculosis	Y	P	N

Cardiovascular

High blood pressure	Y	P	N
Murmurs, arrhythmia	Y	P	N
Angina	Y	P	N
Valve disease	Y	P	N
Palpitations	Y	P	N
Cold extremities	Y	P	N
Deep leg pain	Y	P	N
Varicose veins / phlebitis	Y	P	N
Swelling in ankles	Y	P	N
Strokes / heart attacks	Y	P	N

Gastro – intestinal

Change in appetite	Y	P	N
Impaired swallowing	Y	P	N
Heartburn / indigestion	Y	P	N
Gas	Y	P	N
Bloating	Y	P	N
Abdominal pain	Y	P	N
Nausea	Y	P	N

Vomiting Y P N
 # Bowel Movements / day _____
 Blood in stool Y P N
 Constipation Y P N
 Diarrhea Y P N
 Liver disease / jaundice Y P N
 Gallbladder disease Y P N
 Ulcers Y P N
 Irritable bowel syndrome Y P N
 Hemorrhoids Y P N

Urinary

Pain on urination Y P N
 Increased frequency Y P N
 Awakening at night to urinate Y P N
 Urinary urgency Y P N
 Blood in urine Y P N
 Flank pain Y P N
 Recurrent bladder, kidney infection Y P N
 Kidney stones Y P N
 Incontinence Y P N

Male Reproductive

Pelvic pain Y P N
 Impotence Y P N
 Premature ejaculation Y P N
 Testicular masses Y P N
 Testicular pain Y P N
 Hernias Y P N
 Prostate disease Y P N
 Difficulty starting or stopping urination Y P N
 Breast enlargement or pain Y P N
 Sexually transmitted disease Y P N
 Discharge or sores Y P N
 What do you use for birth control? _____

Sexual preference:

Heterosexual/Bisexual/Homosexual

Female Reproductive

Pelvic pain Y P N
 Post intercourse bleeding Y P N
 Post menopausal bleeding Y P N
 Sexually transmitted disease Y P N
 Discharge or sores Y P N

What do you use for birth control? _____

Sexual preference:

Heterosexual/Bisexual/Homosexual

Breasts

Do you self examine? Y P N
 Lumps Y P N
 Cysts Y P N
 Pain or tenderness Y P N

Nipple discharge Y P N

Musculoskeletal

Joint swelling / inflammation Y P N
 Joint pain / stiffness Y P N
 Arthritis Y P N
 Impaired range of motion Y P N
 Weakness Y P N
 Muscle cramps Y P N
 Bone fractures Y P N
 Disc disease Y P N

Neurological

Seizures Y P N
 Fainting spells Y P N
 Tremor Y P N
 Paralysis Y P N
 Numbness / tingling Y P N
 Loss of memory Y P N
 Weakness Y P N
 Balance problems Y P N
 Speech difficulties Y P N

Blood / lymphatic

Anemia Y P N
 Leukemia Y P N
 Bruising / bleeding easily Y P N
 Lymph gland swelling Y P N
 Transfusions Y P N

Endocrine / Hormonal

Heat / cold intolerance Y P N
 Excessive thirst / hunger Y P N
 Thyroid problems / goiter Y P N
 Diabetes/ Hypoglycemia Y P N
 Excessive facial hair (female) Y P N
 Easy weight gain Y P N

Immune

Frequent colds /infections Y P N
 Allergic disorders Y P N
 Asthma, eczema, hives, etc Y P N
 Do odors bother you Y P N

Psychological

Psychiatric problems or hospitalization Y P N
 Anxiety Y P N
 Depression Y P N
 Drug or alcohol abuse Y P N
 Mood swings Y P N
 Violent potential Y P N
 Obsessive / compulsive Y P N
 Phobias Y P N
 Stressed out Y P N

Additional medical history not included elsewhere that you feel is relevant: _____

NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY. Information contained here will not be released to any person except when you have authorized us to do so.