



Please complete the following form as thoroughly as possible. All information is confidential.

Name: _____ Today's Date: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Phone: (h) _____ Phone: (cell) _____

E-mail: _____ Date of Birth: _____

Care Card / Personal Health Number: _____

Do you have an extended health care plan? Y_____ N_____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Name(s) of other health care providers: _____

Doctor's address / phone: _____

Date of last visit to Doctor: _____

Are you under the care of a medical specialist? Y_____ N_____

Most Important Health Concerns – Please list:

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Do you have any life threatening allergies? Y_____ N_____

Please list any medications and/or vitamins that you are currently taking (include dosage)

_____	_____
_____	_____
_____	_____

What are your goals for this visit?

How did you hear about our clinic? _____

Medical History

Please check if you have had any concerns within the last year or of significance in the past.

MUSCULOSKELETAL

Joint Pain	_____	Osteoarthritis	_____
Muscle Pain	_____	Rheumatoid Arthritis	_____
Headaches	_____	Broken Bones	_____

SKIN

Acne	_____	Psoriasis	_____
Eczema	_____	Hives	_____
Moles change	_____	Sunburn	_____
Itching	_____	Rash	_____
Sores	_____	Excessive dryness	_____

EYES

Impaired Vision	_____	Diabetes	_____
Glaucoma	_____	Blurred vision	_____
Macular degeneration	_____	Laser Surgery	_____

EARS

Impaired hearing	_____	ringing in ears	_____
Earache	_____	History of frequent ear infections	_____

NOSE AND SINUSES

Sinus infections	_____	Nosebleeds	_____
Stuffiness	_____	Hay fever	_____
Sinus pain	_____	Sinus congestion	_____

MOUTH AND THROAT

Sore throat	_____	Trouble swallowing	_____
Gum problems	_____	Strep throat	_____
Tooth pain	_____	Canker sores	_____
Cold sores	_____	Cracked lips	_____

NEUROLOGICAL

Fainting	_____	Seizures	_____
Dizziness	_____	Headaches	_____
Numbness/tingling	_____	Memory Loss	_____

RESPIRATORY

Shortness of breath	_____	Wheezing	_____
Chest congestion	_____	Cough	_____
Sputum	_____	Asthma	_____

CARDIOVASCULAR SYSTEM

High blood pressure _____ High cholesterol _____
Angina/Chest Pain _____ Murmurs _____
Heart Disease _____ Heart attack _____
Heart palpitations _____ Cold Hands/Feet _____

History of heart disease in family _____

DIGESTIVE SYSTEM

Difficulty swallowing _____ Heartburn _____
Stomach pain _____ Change in appetite _____
Nausea _____ Vomiting _____
Gas pain _____ Ulcers _____

Bowel movements How often? _____/day

Do you have blood in your stool? _____

Constipation _____ Colitis _____
Diarrhea _____ IBS _____
Crohn's _____ Gall bladder removal _____

URINARY

Pain on urination _____ Increased frequency _____
Urgency _____ Inability to hold urine _____
Frequent infections _____ Kidney stones _____

ENDOCRINE

Thyroid problems _____ Hot flashes _____
Sugar Cravings _____ Weight Loss _____
Weight Gain _____ Hair Loss _____

IMMUNE SYSTEM

Frequent colds/flu's _____ Allergies _____
Cancer _____ Auto-Immune Disease _____

FEMALE REPRODUCTIVE

Irregular cycles _____ PMS _____
Breast tenderness _____ Fatigue with menses _____
Cramps _____ Heavy periods _____
Skipped cycles _____ Emotional changes _____

Length of period (number of days) _____ Do you bleed between periods? _____

Frequency of cycle (how many days apart are your cycles?) _____

Have you reached menopause? _____ If yes, at what age? _____

Menopausal Symptoms? _____

Have you had a mammogram? _____ If yes, when? _____

Are you currently pregnant? _____ No. of pregnancies _____

No. of live births _____ No. of miscarriages _____

No. of abortions _____ Difficulty conceiving _____

Are you currently sexually active? _____ Sexual difficulties _____

History of STD's _____

Abnormal Pap smear _____ if yes, when _____

Date of last PAP smear _____

MALE REPRODUCTIVE

Hernias _____

Testicular masses/pain _____

Sexually active _____

Sexual difficulties _____

History of STD's _____

Discharge or sores _____

Prostate problems _____

MENTAL/EMOTIONAL

Depression _____

Mood swings _____

Anxiety _____

Anger/frustration _____

Insomnia _____

Phobias _____

Change in appetite _____

Panic Attacks _____

Have you ever been treated for any of these? _____

LIFESTYLE

What are your main interests and hobbies?

Do you eat 3 meals a day? _____

How often do you exercise? _____

Do you stay asleep through night? _____

Hours of sleep/night? _____

Do you wake up feeling rested? _____

Do you enjoy your work? _____

MISCELLANEOUS

When was your last treatment with antibiotics? _____

Have you/ do you ever use recreational drugs? _____

Do you drink alcohol? _____ How many drinks/week? _____

Do you smoke? _____ How many cigarettes/day? _____

Drink coffee or tea? _____ How many cups/day? _____

Any other health concerns or symptoms that you would like to mention: