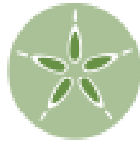

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Please fill out these forms as completely as possible.
This is a confidential record of your medical history and the information contained in it will not be released to any person unless you authorize us to do so.

Name: ____ **Date:** _____________________
Address: ______________________________________ **Phone (H):** ________________
City/Postal Code: ________________ __________ **Phone (B):** ________________
Male Female Age: ______ **Date of Birth:** ___________________________________
Occupation: ____
Marital Status: ___________________________ **Number of children:** ______________

Emergency Contact: ___________________ **Phone:** ___________ **Relation:** _________
Name of Medical Doctor: __________________________ **Phone:** __________________
Referred by: ____

Main Health Concerns in Order of Importance to You

____
____
____
____
____

Please list all current medications (prescription, herbs, vitamins) or regimes that you are currently following

____
____
____
____
____
____

Past Medical History (please check and date)

- ❑ Cancer
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Strep throat
- ❑ Allergies (drugs, chemicals, foods)
- ❑ Diabetes
- ❑ Seizures/epilepsy
- ❑ Thyroid disease/Goitre
- ❑ Hepatitis
- ❑ Sexually Transmitted Disease
- ❑ Arthritis
- ❑ Depression
- ❑ Asthma
- ❑ Eczema
- ❑ Kidney disease
- ❑ Alcoholism or Drug abuse
- ❑ Chicken Pox
- ❑ Emphysema
- ❑ Parasites
- ❑ Mononucleosis
- ❑ Pneumonia
- ❑ Cold sores
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Eating disorders
- ❑ Prostatitis

Family Medical History

Please indicate family member, circle P for Paternal and M for Maternal side of family

- ❑ Cancer M P
- ❑ Diabetes M P
- ❑ Seizures M P
- ❑ High Blood Pressure M P
- ❑ Heart Disease/Stroke M P
- ❑ Asthma M P
- ❑ Allergies M P
- ❑ Arthritis M P
- ❑ Skin diseases M P
- ❑ Depression M P
- ❑ Tuberculosis M P

Major Injuries and Operations

What major injuries or operations have you had? Date

____ ___________

____ ___________

____ ___________

Vaccinations (please check)

- ❑ DPT (Diptheria, Pertussis, Tetanus)
- ❑ MMR (Measles, Mumps, Rubella)
- ❑ Chicken Pox
- ❑ Polio
- ❑ Other ______________________
- ❑ Flu Shot
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hemophilus Influenza B

Did you experience any adverse effects from vaccinations? ______________________________

How often have you been treated with antibiotics in your lifetime? ____

Please check if you are experiencing the following symptoms or write 'P' beside the box if you have experienced these symptoms in the past.

General

- ❑ Poor appetite
- ❑ Weight gain
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Chills and fevers
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Cravings
- ❑ Strong thirst

Skin and Hair

- ❑ Rashes
- ❑ Itching
- ❑ Eczema
- ❑ Acne
- ❑ Loss of hair
- ❑ Dandruff
- ❑ Recent moles
- ❑ Dryness
- ❑ Hives
- ❑ Boils

Eyes Ears Nose Throat

- ❑ Ear aches
- ❑ Ear infections
- ❑ Ringing in ears
- ❑ Sinus infections
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Recurrent sore throat
- ❑ Tonsillitis
- ❑ Nasal obstruction
- ❑ Post nasal drip
- ❑ Nosebleeds
- ❑ Headaches
- ❑ Loss of taste/smell
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Vertigo
- ❑ Cataracts
- ❑ Facial pain/tics
- ❑ Jaw pain or clicks
- ❑ Mercury fillings
- ❑ Sores in mouth

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Irregular heartbeat
- ❑ Dizziness
- ❑ Fainting
- ❑ Chest pain
- ❑ Varicose veins
- ❑ Cold hands or feet
- ❑ Swelling of limbs

Respiratory

- ❑ Difficulty breathing
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Asthma
- ❑ Coughing blood
- ❑ Throat phlegm
- ❑ Wheezing

Muscle, Bone & Joints

- ❑ Neck pain
- ❑ Back pain
- ❑ Muscle pain
- ❑ Muscle weakness
- ❑ Arthritis
- ❑ Bursitis
- ❑ Other pain

Gastrointestinal

- ❑ Gas or burping
- ❑ Bad breath
- ❑ Constipation
- ❑ Diarrhea
- ❑ Abdominal pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Chronic laxative use
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Blood in stool
- ❑ Constant hunger
- ❑ Bloating
- ❑ Intestinal worms
- ❑ Indigestion
- ❑ Bowel movements/day:___

Neurological

- ❑ Loss of balance
- ❑ Irritable
- ❑ Poor memory
- ❑ Anxiety
- ❑ Depression
- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Seizures
- ❑ Concussion
- ❑ Numbness of feet
- ❑ Mood swings

Genito-Urinary

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Pain on urination
- ❑ Wake up at night to urinate
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Kidney infection
- ❑ Prostate problem
- ❑ Impotent
- ❑ Sores on genitals
- ❑ Blood in urine

Female

- ❑ Irregular periods
- ❑ Painful periods
- ❑ Vaginal discharge
- ❑ Vaginal sores
- ❑ Sore breasts
- ❑ Abdominal cramps

Length of cycle: ________
Age of first menses ____
Date of last Pap ________

Menopausal Y N
Age of last menses ____

Pregnant Y N
Birth control _____________
Number of:

- pregnancies _____
- abortions _____
- miscarriages _____
- births _____

Diet

Please list any food sensitivities/allergies:

____

____

Do you have any dietary restrictions (ie. vegetarian, vegan, religious)?

____

____

Please describe a typical day's diet
Breakfast ____
Lunch ____
Dinner ____
Snacks ____
Beverages: *Please indicate how many glasses of each type per day*
Water____ Juice___ Milk____ Coffee ____ Black tea____ Herbal teas ____ Pop ____

Lifestyle

Please indicate if you are currently using

- ❑ Alcohol (# of drinks___/day/week)
- ❑ Tobacco (type and amount _______)
- ❑ Stimulants (type:__________)
- ❑ Recreational drugs
- ❑ Laxatives
- ❑ Diet pills

Describe type and amount of exercise you do:

____

Describe any hobbies/ other recreational activities/ interests:

____

List any pollutants you are exposed to on a regular basis:

____

What is your level of stress? (please identify any major stressors):

____

Is there anything else that you feel is important that has not been covered?

____