Personal Health History:

Today's Date: Mo______/Day______/Yr_____

Name____________________ Age_____ M F Birth Date Mo__/Day__/Yr__

B.C. Care Card Number_____-_____-_____
Name as it appears on Care Card_____________________

Home Address_____________ City _________________ Postal Code________

Home Phone_________ Work Phone_________ Occupation _______________

Spouse's Name__________________________
Children(Name/Age)_______________________

If above is a child: Father and Mother's name____________________________
Who referred you to our clinic? _______________________________________

Number of visits to another Naturopathic Physician this year______
Names of Other Healthcare Providers:
Naturopathic Physician_______________________
Chiropractor________________________________
Massage Therapist___________________________
Medical Doctor______________________________
Specialist__________________________________

YOUR MAIN HEALTH CONCERN (state the ones of priority) :
1.____
2.____
3.____
4.____

When did your problem(s) begin?_____________________________________
Have you been given any diagnosis? Is so, what? _______________________
What measures have you taken to improve your problem (s)? _______________
____

YOUR PAST MEDICAL HISTORY (Please circle):

Abnormal Pap	Heart Attack	Pleurisy
Anemia	Hepatitis	Rheumatic Fever
Arthritis	High Blood Pressure	Rheumatism
Bladder Infections	Hives	Scarlet Fever
Blood Clots	Kidney Stones	Sexually Transmitted Disease
Cancer	Measles	Stomach Ulcers
Chicken Pox	Migraines	Thyroid Problems
Croup	Mononucleosis	Tuberculosis
Gallbladder Problems	Mumps	Other Conditions:
Hayfever	Pneumonia	

Hospitilizaton and/surgeries ____
Significant trauma (auto accidents, falls, etc…) _____________________________________
Allergies (drugs, chemical, foods) ____
Immunizations____
Childhood Illnesses ____

FAMILY MEDICAL HISTORY

Check Those Applicable

	FATHER	MOTHER	BROTHER(s)	SISTER(s)
Age (if living)				
Allergies (Food, Hayfever)				
Anemia				
Arthritis				
Asthma				
Cancer				
Colitis				
Diabetes				
Epilepsy				
Gallbladder Problem				
Gout				
Heart Disease				
High Blood Pressure				
Hypercholesterolemia				
Kidney Disease				
Mental Illness				
Stomach Ulcers				
Stroke				
Tuberculosis				
Age (at death)				
Cause of death				
Other(s)				

Current Medications (prescriptions, over-the-counter drugs, vitamins, herbs)
Please describe any drugs for non-medical purposes.
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DIET

Breakfast:	**Lunch**:	**Dinner**:

How many packs of cigarettes do you smoke a day? ______________________
How much coffee, tea or cola do you drink per week? _____________________
How much alcohol do you drink per week? ______________________________

REVIEW OF SYSTEMS

Please check if the following symptoms are currently a problem or a recurring problem:

GENERAL

- ❑ Weight
- ❑ Weight 1 year ago
- ❑ Maximum weight
- ❑ Weight loss
- ❑ Cravings
- ❑ Strong thirst (cold or hot)
- ❑ Peculiar tastes or smells
- ❑ Sudden energy drop (what time of the day)?
- ❑ Fatigue
- ❑ Localized weakness
- ❑ Poor sleep
- ❑ Fevers
- ❑ Chills
- ❑ Sweat easily
- ❑ Hot or cold intolerance
- ❑ Mood swings
- ❑ Phobias
- ❑ Alcohol/Drug abuse
- ❑ Allergy: Food or Drug
- ❑
- ❑

SKIN AND HAIR

- ❑ Rashes
- ❑ Acne, boils
- ❑ Ulcerations
- ❑ Eczema
- ❑ Hives
- ❑ Itching
- ❑ Recent moles or change in moles
- ❑ Skin cancer
- ❑ Color change
- ❑ Dandruff
- ❑ Loss of hair
- ❑ Change in hair or skin texture
- ❑ Any other hair or skin problems
- ❑ Night sweats
- ❑ Dryness/Moistness
- ❑ Temperature change
- ❑ Nail changes
- ❑

HEAD, EYES, EARS, NOSE AND THROAT

- ❑ Headache
- ❑ Migraines
- ❑ Dizziness
- ❑ Concussions/ Head injury
- ❑ Impaired vision
- ❑ Glasses/Contacts
- ❑ Blurry vision /Double vision
- ❑ Blind spots
- ❑ Spots in front of eyes
- ❑ Night blindness
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Eye pain
- ❑ Redness
- ❑ Itching
- ❑ Tearing
- ❑ Dryness of eyes
- ❑ Eye Discharge
- ❑ Ear Discharge
- ❑ Impaired hearing
- ❑ Ringing in ears
- ❑ Earaches
- ❑ Ear infections
- ❑ Nosebleeds
- ❑ Frequent colds
- ❑ Stuffiness/ Hayfever
- ❑ Recurrent sore throats
- ❑ Sore lips or tongue
- ❑ Loss of taste
- ❑ Gum Problems
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ Facial pain
- ❑ Hoarseness
- ❑ Swollen glands
- ❑ Goiter
- ❑
- ❑
- ❑

CARDIOVASCULAR

- ❑ Heart Disease
- ❑ Irregular heartbeat
- ❑ Palipation, fluttering
- ❑ Chest pains
- ❑ Rheumatic fever
- ❑ Past transfusions
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Dizziness/ Fainting
- ❑ Phlebitis
- ❑ Blood clots
- ❑ Lymph node swelling
- ❑ Swelling of hands
- ❑ Swelling of feet
- ❑ Cold hands or feet
- ❑ Cyanosis
- ❑ Bleed or bruise easily
- ❑ Anemia

RESPIRATORY

- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Pleurisy
- ❑ Tuberculosis
- ❑ Cough
- ❑ Coughing blood
- ❑ Production of phlegm (what colour)?
- ❑ Pain with a deep breath
- ❑ Difficulty in breathing
- ❑ Wheezing
- ❑ Shortness of breath
- ❑ Difficulty in breathing when lying down
- ❑

GASTROINTESTINAL

- ❑ Ulcer
- ❑ Crohns
- ❑ Celiacs disease
- ❑ Liver disease
- ❑ Gallbladder disease
- ❑ Ulcerative Colitis
- ❑ Hernias
- ❑ Heartburn
- ❑ Hemmorrhoids
- ❑ Abdominal pain or cramps
- ❑ Rectal pain
- ❑ Vomiting (Blood?)
- ❑ Nausea
- ❑ Indigestion
- ❑ Poor appetite
- ❑ Change in appetite
- ❑ Change in thirst
- ❑ Belching
- ❑ Bad breath
- ❑ Gas
- ❑ Constipation
- ❑ Chronic laxative use
- ❑ Diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Rectal bleeding
- ❑ Food allergies?

GENITOURINARY

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Decrease flow
- ❑ Do you wake to urinate (how often)?
- ❑ Unable to hold urine
- ❑ Pain on urination
- ❑ Impotency
- ❑ Any particular colour to your urine?
- ❑ Blood in urine
- ❑ Kidney stones
- ❑ Sores on genitals
- ❑ Frequent infections

PREGNANCY AND GYNECOLOGY

- ___Age at first menses
- ___First date of last menses
- ___Days between menses
- ___Duration of menses
- ❑ Menstrual flow: Light, Heavy, Spotting
- ❑ Painful periods
- ❑ Irregular periods
- ❑ Clots
- ❑ Endometriosis
- ❑ Pain during intercourse
- ❑ Difficulty conceiving
- ___Number of pregnancies
- ___Number of live births
- ___Premature births
- ___ Abortions
- ___Miscarriages
- ❑ Birth Control: type_________________
- ❑ Cervical Dysplasia
- ❑ Vaginal discharge
- ❑ Vaginal sores
- ❑ Vaginal itch
- ❑ Last PAP Smear ______
- ❑ Changes in body / psyche prior to menstruation
- ❑ Breast lumps
- ❑ Breast pain/tenderness
- ❑ Nipple discharge
- ❑ Uterine Fibroids

MALE REPRODUCTIVE

- ❑ Hernias
- ❑ Testicular pain
- ❑ Sexual difficulties
- ❑ Venereal disease
- ❑ Prostate Infections
- ❑ Prostate Cancer

- ❑ Testicular masses
- ❑ Discharge or sores
- ❑ Last Prostate Exam_______________

MUSCULOSKELETAL

- ❑ Neck pain
- ❑ Back pain
- ❑ Arthritis
- ❑ Shoulder pain
- ❑ Knee pain
- ❑ Joint swelling
- ❑ Hand/wrist pain
- ❑ Foot/ankle pain
- ❑ Broken bones
- ❑ Muscle spasms or cramps
- ❑ Muscle weakness
- ❑ Any other joint or bone problem?

NEUROPSYCHOLOGICAL

- ❑ Anxiety
- ❑ Fainting
- ❑ Involuntary movement
- ❑ Quick temper/irritable
- ❑ Seizures
- ❑ Areas of numbess
- ❑ Have you ever been treated for emotional problems?
- ❑ Concussion
- ❑ Poor memory
- ❑ Depression
- ❑ Loss of balance
- ❑ Speech problems
- ❑ Easily susceptible to stress
- ❑ Lack of coordination
- ❑ Have you ever considered or attempted suicide?
- ❑ Dizziness
- ❑ Paralysis
- ❑ Any other neurological or psychological problems?

Any other problems you would like to discuss:

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