

GENERAL INFORMATION

DATE:

SURNAME FIRST NAME INITIAL

ADDRESS:

CITY: PROVINCE / STATE

POSTAL CODE / ZIP COUNTRY

PHONE: RES: BUS:

E-MAIL: FAX:

SEX: MALE FEMALE DATE OF BIRTH

PROVINCIAL HEALTH CARE NUMBER

HEIGHT: WEIGHT ALLERGIES

IN AN EMERGENCY CONTACT: MY SPOUSE / PARENT / RELATIVE / FRIEND / OTHER

NAME

AT PHONE # OR

MY FAMILY PHYSICIAN IS:

.....

I AM CURRENTLY EMPLOYED SELF-EMPLOYED UN-EMPLOYED ON LEAVE

OR RETIRED MY OCCUPATION IS:

I FOUND OUT ABOUT THE CENTRE FOR PREVENTIVE MEDICINE FROM:

FRIEND / RELATIVE

NEWSPAPER

THE INTERNET

ANOTHER PROFESSIONAL

RADIO

YELLOW PAGES

MAGAZINE AD

MY FAMILY PHYSICIAN

OUTDOOR SIGN

OTHER:

MEDICAL HISTORY

CURRENT

LIST ALL DOCTORS, PHYSIOTHERAPISTS, CHIROPRACTORS, NATUROPATHS, ETC. THAT YOU SEE NOW:

1.....3.....

2.....4.....

LIST ALL CURRENT MEDICATIONS & DOSAGES:

1.....3.....

2.....4.....

LIST ALL NON-PRESCRIPTION MEDICATIONS (VITAMIN OR HERBAL):

1.....3.....

2.....4.....

LIST ANY KNOWN MEDICATION ALLERGIES:

.....

FOOD ALLERGIES?

.....

INHALENT ALLERGIES?

.....

CHEMICAL ALLERGIES?

.....

HISTORY

SMOKING HISTORY - WHEN DID YOU START? HOW MUCH DID YOU SMOKE? WHEN DID YOU QUIT?

ALCOHOL CONSUMPTION (AMOUNT CONSUMED, TYPE & FREQUENCY)
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FAMILY HISTORY

	AGE IF ALIVE	AGE AT DEATH	MAJOR HEALTH PROBLEMS / CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS			
SISTERS			

LIST ALL HOSPITALIZATIONS & SURGERIES:

NAME & PLACE	DATE	REASON

LIST ALL ACCIDENTS, INJURIES, BROKEN BONES ETC:

DATE	INJURY	CAUSE

RADIATION OR CHEMOTHERAPY:

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PAST MEDICAL PROBLEMS: CHECK ALL THAT APPLY

RESPIRATORY SYSTEM

CHRONIC COUGH		COUGHING UP BLOOD	
WHEEZE / ASTHMA		PNEUMONIA	
EMPHYSEMA		ABNORMAL CHEST X-RAY	
TUBERCULOSIS		HAYFEVER	

CARDIOVASCULAR SYSTEM

ANGINA		HIGH BLOOD PRESSURE	
PALPITATIONS		LOW BLOOD PRESSURE	
IRREGULAR PULSE		HEART MURMUR	
RHEUMATIC FEVER		BLOOD CLOT IN LEGS	
HIGH CHOLESTEROL		SWELLING OF ANKLES	

URINARY SYSTEM

FREQUENT URINATION		DIFFICULT URINATION	
KIDNEY / BLADDER INFECTION		PROTEIN / BLOOD IN URINE	

CENTRAL NERVOUS SYSTEM

EPILEPSY		MULTIPLE SCLEROSIS	
MIGRAINE HEADACHES		PARALYSIS	
TENSION HEADACHES		POOR CONCENTRATION	
TREMORS		DIZZINESS	
NUMBNESS / TINGLING		FORGETFULNESS	

MUSCULAR SKELETAL SYSTEM

OSTEOARTHRITIS		RHEUMATOID ARTHRITIS	
GOUT		SHOULDER NECK ARM PAIN	
BACK PAIN		CARPAL TUNNEL	
TENDONITIS		BURSITIS	
JOINT PAIN		MUSCLE CRAMPS	

SKIN

SKIN CANCER		ECZEMA	
CHANGED MOLES		ACNE	
RASH		VARICOSE VEINS	
PSORIASIS		DRY SKIN	
HEMORRHOIDS		ABDOMINAL REFLUX	

EYES

CATARACTS		GLAUCOMA	
BLINDNESS		MACULAR DEGENERATION	
POOR NIGHT VISION		INFECTED EYES / LIDS	

EARS

DEAFNESS		RINGING	
CHRONIC INFECTION		WAX BUILD UP	

NOSE

HAYFEVER		POLYPS	
SINUSITIS		RUNNY NOSE	
STUFFED NOSE			

GASTRO-INTESTINAL SYSTEM

POOR APPETITE		NAUSEA	
INDIGESTION		HIATUS HERNIA	
IRRITABLE BOWEL		HEPATITIS	
CONSTIPATION / DIARRHEA		ULCER	
HEMORRHOIDS		ABDOMINAL REFLUX	

PSYCHOLOGICAL

DEPRESSION		ANXIETY	
BIPOLAR AFFECTIVE DISORDER		PSYCHOSIS	
EXCESSIVE STRESS		SUICIDAL THOUGHTS	

ENDOCRINE (HORMONE) SYSTEM

WEIGHT GAIN		COLD HANDS	
HAIR LOSS		POOR RESISTANCE TO INFECTION	
INTOLERANCE TO COLD		INTOLERANCE TO HEAT	
LOW BLOOD SUGAR		THYROID PROBLEM	
DIABETES		FAINING SPELLS	

IMMUNIZATIONS

SMALL POX		TETANUS	
POLIO		MEASLES	
RUBELLA		DIPHTHERIA	

COMPLAINTS: PLEASE LIST ALL KNOWN DIAGNOSES AS WELL AS CURRENT SYMPTOMS

- 1.....2.....
- 3.....4.....
- 5.....6.....
- 7.....8.....

BRIEFLY DESCRIBE WHEN YOUR PROBLEMS BEGAN, HOW THEY BEGAN AND HOW YOU CURRENTLY EXPERIENCE YOUR PROBLEMS

REPRODUCTIVE SYSTEM - FEMALE

MENSTRUAL HISTORY

AGE PERIODS BEGAN CEASED, *IF APPLICABLE*

DAYS BETWEEN PERIODS LENGTH OF PERIODS

DATE OF LAST PAP DATE OF LAST BREAST EXAM

OF PREGNANCIES # OF MISCARRIAGES

BIRTH CONTROL METHOD

HORMONE SUPPLEMENT(S)

HISTORY OF BREAST CANCER ON MOTHER'S SIDE

CHECK ALL THAT APPLY

HYSTERECTOMY		TUBAL LIGATION	
OVARIES REMOVED		ABNORMAL PAP SMEAR	
PMS		INFERTILITY	
YEAST INFECTIONS		FIBROCYSTIC BREAST DISEASE	
FREQUENT ANTIBIOTIC USE		LOSS OF SEX DRIVE	
ENDOMETRIOSIS		FIBROIDS	
IRREGULARITY		PAINFUL PERIODS	
SWEET CRAVING		SALT CRAVING	

OTHER GYNECOLOGICAL PROBLEMS

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Nutrition & Diet

HOW MANY MEALS DO YOU EAT EACH DAY?.....

DO YOU FREQUENTLY DIET?.....

ARE YOU DIETING NOW?.....

DO YOU CONSIDER YOURSELF - JUST RIGHT? OVERWEIGHT? UNDERWEIGHT?

DO YOU SNACK IN BETWEEN MEALS: RARELY/NEVER SOMETIMES FREQUENTLY

CHECK THE FREQUENCY YOU EAT THE FOLLOWING FOODS

FOOD	MORE THAN ONCE /DAY	DAILY	3 X WEEK	1 X WEEK	RARELY OR NEVER	TYPE
BREAKFAST						
CEREAL						
BREAD						
PASTA						
RICE/GRAINS						
SUGAR/CANDY						
FRUIT JUICE						
DESSERTS						
MILK						
CHEESE						
YOGURT						
ICE-CREAM						
MARGARINE						
BUTTER						
RED MEAT						
FISH						
CHICKEN						
PROCESSED MEAT						
BEANS/PEAS						
NUTS & SEEDS						
VEGETABLES						
SPICY FOODS						
COFFEE/TEA						
ALCOHOL						