

Name _____ Date _____ Birth date (M) _____ (D) _____ (Y) _____ Sex M / F
Street _____ Home Phone _____ Height _____ Weight _____
City _____ Prov _____ PC _____ Work Phone _____ Email _____ Occupation _____

YOUR MEDICAL HISTORY

- Cancer □ High Blood Pressure
□ Hepatitis □ Heart Disease
□ Thyroid Disease □ Diabetes Allergies
□ Rheumatic Fever □ Other _____

FAMILY MEDICAL HISTORY

- Cancer □ Alcoholism
□ Diabetes □ Stroke/Seizure
□ Asthma Allergies □ Heart Disease
□ High Blood Pressure □ Oher _____

HABITS

- Alcohol □ Coffee □ Cola
□ Salt □ Sugar
□ Other _____

CHIEF COMPLAINT/S _____ HOW LONG _____

CURRENT THERAPIES _____

GENERAL

- Fever □ Wake up easily □ Poor appetite □ Bleed / Bruise easily
□ Chills □ Sudden energy drop at □ Heavy appetite □ Sweat easily
□ Night sweats □ Fatigue □ Thirsty □ Peculiar taste / smell
□ Difficulty falling asleep □ Tremors □ Allergies

SKIN & HAIR

- Rashes □ Itching □ Eczema □ Hives
□ Hair loss □ Acne □ Psoriasis □ Other _____

HEAD, EYES, EARS, NOSE & THROAT

- Dizziness getting up □ Headaches □ Dry Mouth / Throat □ Sinus problems
□ Dizziness laying down □ Migraines □ Nose bleeds □ Poor hearing
□ Night blindness □ Sore eyes □ See spots □ Recurrent sore throat
□ Blurry vision □ Ear aches □ Grinding teeth □ Sores on lips / tongue
□ Ringing in ears □ Gum problems □ Excess saliva □ Mucus /Phlegm

CARDIOVASCULAR & RESPIRATORY

- High / Low blood pressure □ Bronchitis □ Chest pain □ Varicose veins
□ Irregular heart beat □ Cough □ Fainting □ Cold hand / feet
□ Shortness of breath □ Asthma □ Phlebitis □ Swelling hands / feet

GASTROINTESTINAL

- Bowel Movement _____ x / day □ Odor-very strong □ Haemorrhoids □ Nausea
□ Constipation □ Bloody / Black stools □ Rectal pain □ Vomiting
□ Diarrhea or □ Laxative use □ Pain or cramps □ Belching
□ Alternating □ Gas □ Rectal prolapse □ Bad breath

GENITO-URINARY

- Frequent urination □ Wake up to urinate □ Blood in urine □ Impotence
□ Urgency to urinate □ Painful urination □ Unable to hold urine □ Kidney stones

GYNAECOLOGICAL

- Period (reg 28 days irreg) □ Breast lumps / swelling □ Discharge □ Premature births
Duration _____ days? □ Painfull period □ Birth control □ Pregnant? □ Yes □ No
Last period _____ Mood changes □ Menopause (age?) □ Miscarriages
Flow: □ Heavy □ Med □ Light □ Clots □ Spotting Colour: □ Dark □ Light □ Med # Pegnancies _____ # Births _____

MUSCULO-SKELETAL

- Joint Pains □ Muscle pains □ Neck pain □ Back pain

NEUROPHYSIOLOGICAL

- Anxiety / fear □ Poor memory □ Depression □ Areas of numbness
□ Easily stressed □ Bad temper □ Treated for emotional problems Other _____