Okanagan Naturopathic Healthcare Inc.

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Identifying Data

Name: _____
Age: _____ Date of Birth: _____
Sex: M or F Marital Status: _____
Nationality / Race: _____
Number of Children: _____
Occupation: _____
Home Address: _____
City: _____
Province: _____ Postal Code: _____

Telephone # (home): _____
(work or cell): _____
E-mail address: _____
Emergency Contact: _____
Telephone #: _____
Family M.D.: _____
How did you hear about us/who referred you?
_____
Care Card #_____

I am aware that all tests, procedures and prescriptions are my responsibility and must be paid for at the time services are rendered.

Signed: _____ Date: _____

What is your commitment level to being proactive in your health care? _____

Major Health Concerns (in order of priority)
1) _____
2) _____
3) _____

Has anything recently changed or become worse?

_____
_____

What questions do you have that you would like answered?

_____
_____

Were there any significant events that preceded the beginning of your chief concern? (e.g. accident, illness, surgery, stress, etc.)

_____
_____

Other practitioners you are currently seeing or have recently seen and treatments you are receiving.

Name	Type of Practitioner	Treatment
1)		
2)		
3)		
4)		
5)		

Family Medical History: Please list the current age and relevant medical problems. If deceased, list age and cause of death.

Mother: _____
Father: _____
Brothers: _____
Sisters: _____
Spouse: _____
Children: _____
Any Familial diseases: _____

Which childhood diseases have you had (please circle): Chicken pox mumps measles whooping cough rheumatic or scarlet fever diphtheria polio other _____

As an infant were you breast fed? Yes or No
For how long?_____(months)

Immunizations: complete or partial
Adverse reactions?_____

Past Surgeries: (circle and date)

Tonsils-	appendix-	gallbladder-
Hernia-	tubal ligation-	vasectomy-
Minor surgery-	back-	varicose veins-
Cosmetic-	skin lesions-	hysterectomy-
Prostate-	other-	

Past Hospitalizations: (date, reason & length of stay)

_____
_____
_____
_____

Past Medical Illness: (date & describe all major illnesses)

_____
_____
_____
_____

Dental History: (circle and date)
Silver amalgams/crowns_____
Gold amalgams/crowns_____
Dental implants_____
Wisdom teeth removed_____
Root canals_____
Dental appliances/bridges/dentures _____
What condition are your gums in? _____

Allergies and Drug Reactions: List and describe the reaction.
Drug:_____
_____
Food:_____
_____
Chemical:_____
_____
Pollens/Molds:_____
_____
Insects/Animals:_____
_____

Current Medications: List ALL prescription, over the counter, health food store, multi-level marketed drugs, supplements, herbs etc. you take regularly and their dosage

_____
_____
_____
_____

Menstrual History:
Age of onset: _____Date of last period: _____ Date of last PAP smear:_____
Was it normal? _____ Number of days between periods: _____
Duration of bleeding: _____
Amount of blood loss: _____ P.M.S. or cramps? _____
Would you say your period is regular? _____
List any past menstrual or gynecological problems: _____
_____
Difficulty conceiving? _____ Number of pregnancies: _____
Number of deliveries: _____
Any birth complications? _____
Number of cesarean sections: _____
Number of miscarriages: _____Number of abortions_____
Number of D & Cs:_____
Age at menopause_____ Menopausal symptoms: _____
_____

Personal Profile / Social History

Dietary Habits: Briefly list what you eat and drink at a typical meal.

Breakfast:
_____
Lunch:
_____
Dinner:
_____
Snacks:
_____

How do you rate your diet? Excellent good average poor terrible
Do you follow a specific diet? Yes or No
What kind? _____
Amount of water intake (daily) _____What type? Tap bottled home filtered
Do you smoke? Yes or No How much per day? _____ Type _____
Recreational drug use: Yes or No Is this a concern for you? Yes or No
Alcohol use: daily several times per week weekend only occasional rarely never
Alcoholic beverage of choice _____ Amount consumed per use_____

Employment History: How many hours per day do you work?_____
Please briefly list all major jobs/ occupations in the past.

_____
_____
_____

Education History: What is the highest level of education you have completed?

_____

Travel history: Have you been out of the country recently? Yes or No
When? _____ For how long? _____
Where? _____
Are any of your health problems related to your travels? Yes or No

Marital History: Any major problems with your marriage/ common law partner? Yes or No
Any past divorces? Yes or No How Many?_____
Are you sexually active? Yes or No
Any sex-related concerns? Yes or No
Please briefly describe_____

General Health:

Do you exercise regularly? Yes or No
Type(s) _____
How often? _____
For how long? _____
Do you sleep through the night? Yes or No
# of hours per night _____
Do you sleep well? Yes or No
Do you awaken feeling rested? Yes or No

Pets at home? Yes or No
How many? _____
What kind? _____
How long have you had them? _____
Where do they sleep?_____

Do you regularly relax, meditate, or pray?
Yes or No
What do you do for stress management?
_____
_____
Age of the home that you live in: _____
Is dust or mold a problem in your house?
Yes or No
Has there been any recent renovations done in your home in the last 3 years? _____
Do you like your home and where you live?
Yes or No
Any financial difficulties? Yes or No
Recent or long term? _____

Present weight_____ (lbs) Height_____
Date of last physical_____
Maximum weight_____ (lbs) When?_____
Desired weight? _____ (lbs)

Review of Systems

Beside the following list, please indicate if it is a condition you have **now** by circling - **Y**. If it is a condition you have had in the **past**, but is okay now, circle - **P**. Circle -**N** if it is a condition you have **never** had. Record significant details in the margins.

General Body

Fatigue	Y	P	N
Fever	Y	P	N
Chills	Y	P	N
Night sweats	Y	P	N

Skin

Eczema / rash	Y	P	N
Psoriasis	Y	P	N
Acne, boils	Y	P	N
Hives	Y	P	N
Peculiar moles	Y	P	N
Lumps/ growths	Y	P	N
Bruising	Y	P	N
Pigmentation change	Y	P	N
Itch	Y	P	N
Infections	Y	P	N

Hair

Abnormal loss	Y	P	N
Change in texture	Y	P	N

Nails

Brittle	Y	P	N
Ridging	Y	P	N
Pitting	Y	P	N
Abnormal curvature	Y	P	N
Not growing	Y	P	N

Head

Stress headache	Y	P	N
Migraine headache	Y	P	N
Head injury	Y	P	N
Head pain	Y	P	N

Neck

Swollen glands	Y	P	N
Pain or stiffness	Y	P	N

Eyes

Impaired vision	Y	P	N
Double vision	Y	P	N
Cataracts	Y	P	N
Glaucoma	Y	P	N
Eye pain	Y	P	N
Discharge	Y	P	N
Tearing	Y	P	N
Dryness	Y	P	N
Redness	Y	P	N
Burning /itching	Y	P	N
Light sensitivity	Y	P	N
Blindness	Y	P	N
Glasses or contacts	Y	P	N

Ears

Impaired hearing	Y	P	N
Ringing	Y	P	N
Dizziness	Y	P	N
Recurrent infections	Y	P	N
Discharge	Y	P	N
Earache/itch	Y	P	N

Nose / Sinuses

Impaired smell	Y	P	N
Nose bleeds	Y	P	N
Nasal / sinus congestion	Y	P	N
Runny nose	Y	P	N
Recurrent infection	Y	P	N
Post nasal drip	Y	P	N
Hayfever	Y	P	N

Mouth / Throat

Impaired taste	Y	P	N
Recurrent sore throat/ infections	Y	P	N
Gum disease	Y	P	N
Sore tongue	Y	P	N
Hoarsness / laryngitis	Y	P	N
Bad breath	Y	P	N
Canker sores	Y	P	N

Respiratory

Chronic cough	Y	P	N
Shortness of breathe	Y	P	N
Difficulty breathing	Y	P	N
Wheezing	Y	P	N
Blood in sputum	Y	P	N
Chest pain	Y	P	N
Recurrent pneumonia/bronchitis	Y	P	N
Asthma	Y	P	N
Emphysema	Y	P	N
Tuberculosis	Y	P	N

Cardiovascular

High blood pressure	Y	P	N
Murmurs, arrhythmia	Y	P	N
Angina	Y	P	N
Valve disease	Y	P	N
Palpitations	Y	P	N
Cold extremities	Y	P	N
Deep leg pain	Y	P	N
Varicose veins / phlebitis	Y	P	N
Swelling in ankles	Y	P	N
Strokes / heart attacks	Y	P	N

Gastro – intestinal

Change in appetite	Y	P	N
Impaired swallowing	Y	P	N
Heartburn / indigestion	Y	P	N
Gas	Y	P	N
Bloating	Y	P	N
Abdominal pain	Y	P	N
Nausea	Y	P	N

Vomiting	Y	P	N	Nipple discharge	Y	P	N
# Bowel Movements / day _____				**Musculoskeletal**			
Blood in stool	Y	P	N	Joint swelling / inflammation	Y	P	N
Constipation	Y	P	N	Joint pain / stiffness	Y	P	N
Diarrhea	Y	P	N	Arthritis	Y	P	N
Liver disease / jaundice	Y	P	N	Impaired range of motion	Y	P	N
Gallbladder disease	Y	P	N	Weakness	Y	P	N
Ulcers	Y	P	N	Muscle cramps	Y	P	N
Irritable bowel syndrome	Y	P	N	Bone fractures	Y	P	N
Hemorrhoids	Y	P	N	Disc disease	Y	P	N
Urinary				**Neurological**			
Pain on urination	Y	P	N	Seizures	Y	P	N
Increased frequency	Y	P	N	Fainting spells	Y	P	N
Awakening at night to urinate	Y	P	N	Tremor	Y	P	N
Urinary urgency	Y	P	N	Paralysis	Y	P	N
Blood in urine	Y	P	N	Numbness / tingling	Y	P	N
Flank pain	Y	P	N	Loss of memory	Y	P	N
Recurrent bladder, kidney infection	Y	P	N	Weakness	Y	P	N
Kidney stones	Y	P	N	Balance problems	Y	P	N
Incontinence	Y	P	N	Speech difficulties	Y	P	N
Male Reproductive				**Blood / lymphatic**			
Pelvic pain	Y	P	N	Anemia	Y	P	N
Impotence	Y	P	N	Leukemia	Y	P	N
Premature ejaculation	Y	P	N	Bruising / bleeding easily	Y	P	N
Testicular masses	Y	P	N	Lymph gland swelling	Y	P	N
Testicular pain	Y	P	N	Transfusions	Y	P	N
Hernias	Y	P	N	**Endocrine / Hormonal**			
Prostate disease	Y	P	N	Heat / cold intolerance	Y	P	N
Difficulty starting or stopping urination	Y	P	N	Excessive thirst / hunger	Y	P	N
Breast enlargement or pain	Y	P	N	Thyroid problems / goiter	Y	P	N
Sexually transmitted disease	Y	P	N	Diabetes/ Hypoglycemia	Y	P	N
Discharge or sores	Y	P	N	Excessive facial hair (female)	Y	P	N
What do you use for birth control? _____				Easy weight gain	Y	P	N
Sexual preference:				**Immune**			
Heterosexual/Bisexual/Homosexual				Frequent colds /infections	Y	P	N
Female Reproductive				Allergic disorders	Y	P	N
Pelvic pain	Y	P	N	Asthma, eczema, hives, etc	Y	P	N
Post intercourse bleeding	Y	P	N	Do odors bother you	Y	P	N
Post menopausal bleeding	Y	P	N	**Psychological**			
Sexually transmitted disease	Y	P	N	Psychiatric problems or			
Discharge or sores	Y	P	N	hospitalization	Y	P	N
What do you use for birth control? _____				Anxiety	Y	P	N
Sexual preference:				Depression	Y	P	N
Heterosexual/Bisexual/Homosexual				Drug or alcohol abuse	Y	P	N
Breasts				Mood swings	Y	P	N
Do you self examine?	Y	P	N	Violent potential	Y	P	N
Lumps	Y	P	N	Obsessive / compulsive	Y	P	N
Cysts	Y	P	N	Phobias	Y	P	N
Pain or tenderness	Y	P	N	Stressed out	Y	P	N

Additional medical history not included elsewhere that you feel is relevant: _____

_____

NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY. Information contained here will not be released to any person except when you have authorized us to do so.