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ADULT INTAKE

First name:_____ Initial:_____ Last name: _____ M ____ F ___

Address:_____ City: _____ Postal Code: _____

Please list only the numbers at which we may contact you.

Web site:_____ E-Mail: _____

Home phone: _____ Bus phone: _____ Ext: ___

Cell Phone: _____ Fax: _____

How did you hear about our clinic?:_____

Date of birth: _____ Occupation: _____

Marital Status: _____ Name of Spouse: _____ # Dependents: ___

Emergency contact: _____ Phone: _____

Other health care providers:

Name: _____ Name: _____ Name:_____

Designation: _____ Designation: _____ Designation: _____

Phone: _____ Phone: _____ Phone:_____

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHOURIZED US IN WRITING TO DO SO. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

What health concerns problems brought you to this office today?_____
_____
_____

If this is a chronic illness, how long have you had this condition?_____

Who diagnosed your illness? _____ When was the diagnosis made?_____

What specialists have you seen? (Indicate the year of consultation) _____
_____

If you are a female are you currently pregnant? YES NO

CURRENT MEDICATIONS

List all CURRENT prescribed medications:

Drug name:_____ Dosage:_____ Length taken:_____
Drug name:_____ Dosage:_____ Length taken:_____
Drug name:_____ Dosage:_____ Length taken:_____
Drug name:_____ Dosage:_____ Length taken:_____

List all CURRENT non-prescription medication used:

_____
_____
_____

List all CURRENT vitamins, minerals, herbs, that you take more than occasionally:

_____
_____
_____

List all PAST prescribed medications that you've taken for longer than 3 months:

_____
_____
_____

List any prescribed medication you've had an adverse reaction to in the past. Indicate the drug name, when you took it and the reaction you had:

Drug name:_____ When taken:_____ Reaction:_____
Drug name:_____ When taken:_____ Reaction:_____
Drug name:_____ When taken:_____ Reaction:_____

List all known allergies:

_____
_____
_____

How many times have you been treated with antibiotics in the past 5 years?_____

Family Medical History

	Age	Health problems	If deceased, cause	Age at death
Father				
Mother				
Siblings				
Children				
Grandparents				

MEDICAL HISTORY

Please check only those that pertain to you personally

☐Alcohol abuse	☐Female Gynaecological problems	☐Skin problems
☐Allergies	☐Gallstones	☐Stroke
☐Anaemia	☐Gum/Teeth problems	☐Suicide
☐Asthma	☐Heart attack	☐Thyroid problems
☐Arthritis	☐Heart problems	☐Tuberculosis
☐Back, Muscle, Joint pain	☐High blood pressure	☐Ulcers
☐Bladder/Urinary problems	☐Kidney problems	☐Venereal disease
☐Candida	☐Measles	☐Chronic fatigue
☐Epilepsy	☐Depression	☐Liver problems
☐Diabetes	☐Overweight	☐Chronic sinusitis
☐Rheumatic fever	☐Psychological problems	☐Cancer
☐Lung problems	☐Pneumonia	☐Gout
☐Mononucleosis	☐Eczema	☐Bowel disease
☐Influenza	☐Hay fever	☐Constipation
☐Rheumatism	☐Pleurisy	☐Hives
☐Malaria	☐Chronic swollen glands	☐Hypoglycaemia

Blood type: _____

Date of last physical exam: _____ For what reason? _____

Do you get regular SCREENING TESTS done by another doctor? (Pap, blood test, etc.) YES NO

PERSONAL HEALTH HABITS

Height: _____ Current weight: _____ Weight 1 year ago: _____ Max weight: _____ Year: _____

Smoker? YES NO Amount/day? _____ Years smoked? _____ Year stopped? _____

Are you exposed to smoking at home? YES NO Are you exposed to smoking at work? YES NO

Alcohol use? YES NO Type: _____ Frequency: _____

Recreational drug use? YES NO Type: _____ Frequency: _____

Caffeine use ? YES NO Type: _____ Frequency: _____

Are there any food groups that you avoid? YES NO
What? _____ Why? _____
_____ _____
_____ _____

Are you frequently exposed to animals? YES NO What type? _____

Are you regularly exposed to toxins or other hazards? YES NO

What kind? _____

Do you exercise regularly? YES NO Type:_____ Frequency:_____

How many hours do you sleep per night?_____ Do you wake rested: YES NO

How many hours do you work each day?_____ Do you do shift work? YES NO

What level of personal stress are you experiencing right now?

☐Minimal ☐Average ☐Considerable ☐Unbearable

The main stressor is:

☐Financial ☐Job related ☐Marriage ☐Health
☐Interpersonal ☐Unfulfilled expectations ☐Family ☐Spiritual

What do you do to deal with stress? _____

When was your last vacation?_____ Where did you go?_____

What are your hobbies?_____

CHRONOLOGICAL HEALTH HISTORY

This sort of health history helps to establish trends in a person's health that may be relevant to present conditions. Indicate below any accidents, broken bones, falls, illnesses, hospitalization, surgeries, and any emotional traumas such as deaths, loss of jobs, divorces, etc.

Year 1-5 _____
Year 6-10 _____
Year 10-15 _____
Year 16-20 _____
Year 21-25 _____
Year 26-30 _____
Year 31-35 _____
Year 36-40 _____
Year 41-45 _____
Year 46-50 _____
Year 51-55 _____
Year 55-60 _____
Year 61-65 _____
Year 66-70 _____
Year 71-75 _____
Year 76-80 _____
Year 81-90 _____

Mothers state of health during her pregnancy with you, if you know?

_____

How was your birth? Any complications?

_____

SYMPTOMS REVIEW

Please check (√) Y if you have the symptom now, and P if the symptom is in the past.

SKIN	Y	P
Rashes		
Hives		
Acne		
Boils		
Eczema		
Psoriasis		
Dry skin		
Itching		
Lumps		
Night sweats		
Other		

HEAD	Y	P
Tension headaches		
Migraine headaches		
Head injury		
Dizziness		
Other		

EYE	Y	P
Impaired vision		
Use of contact lenses		
Eye pain		
Tearing		
Dryness		
Double vision		
Glaucoma		
Cataracts		
Blurring		
Light sensitive		
Itching		
Redness		
Discharge		
Blind spot		
Other		

EARS	Y	P
Impaired hearing		
Earache		
Dizziness		
Discharge		
Infections		
Excessive wax		
Other		

NOSE & SINUSES	Y	P
Frequent colds		
Nose bleeds		
Stuffiness		
Hay fever		
Infections		
Other		

MOUTH & THROAT	Y	P
Hoarseness		
Gum problems		
Difficulty swallowing		
Dental problems		
Sores		
Dryness		
Sore throat		
Loss of taste		
Other		

NECK	Y	P
Lumps		
Swollen glands		
Goiter		
Pain or stiffness		
Other		

RESPIRATORY	Y	P
Cough		
Sputum		
Spitting up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Difficulty breathing		
Pain on breathing		
Shortness of breath		
Shortness of breath at night		
Shortness of breath when lying		
Positive tuberculin test		
Last TB test		
Last chest X-ray		
Other		

CARDIOVASCULAR	Y	P
Angina		
Murmurs		
Chest pain		
Swelling in ankles		
Palpitation, fluttering		
Last ECG		
Other		

BREASTS	Y	P
Do you do breast self exam?		
Lumps		
Pain (or tenderness)		
Nipple discharge		
Last mammogram		
Other		

GASTROINTESTINAL	Y	P
Trouble swallowing		
Heartburn		
Change in appetite		
Nausea		
Vomiting		
Vomiting blood		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		
Constipation		
Blood in stool		
Hemorrhoids		
Black, tarry stool		
Jaundice		
Liver disease		
Gallbladder disease		
Food allergy		
Hiatus hernia		
Last colonoscopy		
Other		

BLOOD/LYMPHATIC	Y	P
Anaemia		
Easy bleeding/bruising		
Past transfusions		
Lymph node swelling		
Other		

URINARY	Y	P
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced urine flow		
Other		

MALE REPRODUCTIVE	Y	P
Hernia		
Testicular masses		
Testicular pain		
Impotence		
Premature ejaculation		
Venereal disease		
Discharge of sores		
Sexually active		
Check sexual preference:		
Heterosexual		
Homosexual		
Bisexual		
Last prostate exam		
Last PSA level		
Other		

FEMALE REPRODUCTIVE	Y	P
Age of first menses		
Last menstrual period		
Number of days of menses		
Length of cycle		
Bleeding between periods		
Irregular cycles		
Pain during intercourse		
Painful menses		
Excessive flow		
PMS		
Number of pregnancies		
Number of life births		
Number of miscarriages		
Number of abortions		
Difficulty conceiving		
Sexual difficulties		
Vaginal discharge		
Vaginal itching		
Sexually active		

FEMALE REPRODUCTIVE	Y	P
Check sexual preference:		
Heterosexual		
Homosexual		
Bisexual		
Menopause		
Age of onset		
Hormone therapy		
Last gynaecological exam		
Last pap smear		
Other		

MUSCULOSKELETAL	Y	P
Broken bones		
Muscle spasms/cramps		
Weakness		
Joint swelling		
Backache		
Other		

PEREPHERAL VASCULAR	Y	P
Deep leg pain		
Cold hands/feet		
Varicose veins		
Thrombophlebitis		
Leg cramps		
Extremity numbness		
Extremity coldness		
Extremity swelling		
Extremity ulcers		
Other		

NEUROLOGIC	Y	P
Fainting		
Seizure/Convulsions		
Paralysis		
Muscle weakness		
Numbness or tingling		
Loss of memory		
Involuntary movements		
Loss of balance		
Speech problems		
Other		

ENDOCRINE	Y	P
Heat or cold intolerance		
Thyroid trouble		
Excessive thirst		
Excessive hunger		
Excessive urination		
Excessive sweating		
Diabetes		
Hypoglycemia		
Hormone therapy		
Other		

EMOTIONAL	Y	P
Depression		
Angry		
Mood swings		
Anxiety		
Nervousness		
Tension		
Phobias		
Insomnia		
Sexual difficulties		
Drug abuse		
Psychiatric care		
Psychological counselling		
Other		