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Health History Questionnaire
Naturopathic health care and preventive medicine are only possible when the physician has complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. This information will remain confidential. Please mark anything you do not understand with a question mark.

PERSONAL INFORMATION – please print

Last Name: _____ First Name: _____ Age: _____

Address: _____ Date of birth: _____

City: _____ Province: _____ Postal Code: _____ Sex: M F

Telephone: (Home) _____ Telephone: (mobile) _____

Occupation: _____ Email address: _____

PHN No. (carecard): _____

Are you: __Married __Separated __Divorced __Widowed __Single

Live with: __Spouse __Partner __Friends __Other Children: Y N How many? ____

What health concerns brought you to this office today?

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Has anything recently changed or become worse?

_____

_____

CURRENT MEDICATIONS & SUPPLEMENTS
Please list all your prescription medications (such as sleeping pills, birth control pills), non-prescription medications, (such as aspirin, antacids, laxatives, antihistamines), vitamins, minerals, herbs, etc, that you take more than occasionally.

_____

_____

KNOWN ALLERGIES
Please list any known allergies to medicine, (such as penicillin, sulpha drugs, aspirin), or other substances (such as pollens, ragweed), foods, chemicals etc.

_____

_____

HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES

DATE	INJURY OR REASON FOR HOSPITALIZATION

PERSONAL HEALTH HABITS

Height:_____ Current Weight:_____lbs. Weight 1 year ago:_____lbs. Maximum weight:_____lbs.

Smoker: Y N Smoked for ___ years Amount per day: _____ Year stopped, if applicable _____

Alcohol use: Y N Type of alcohol preferred:_____ Frequency:_____

Recreational Drug Use: Y N Type: _____ Frequency:_____

Coffee: Y N Cups per day ____ Tea: Y N Cups per day

Diet: Are there any food groups that you avoid? Y N If yes, what?_____

Do you exercise regularly? Y N Type:_____ Duration:_____ Frequency: _____

Hobbies:_____

Do you meditate or pray: Y N

Blood Type (if known): A B AB O Additional information:_____

Women: Are you currently pregnant? Y N

PERSONAL MEDICAL HISTORY

Please check only those that pertain to you personally.

___ Alcohol Abuse	___Allergies	___Anemia	___Arthritis
___Asthma	___Back, Muscle, Joint Pain	___Bladder/Urinary Problems	___Colitis
___Depression	___Thyroid Problems	___Epilepsy	___Fatigue
___Female Gynecological Issues	___Gallstones	___Gum/Teeth Problems	___Ulcers
___Heart Problems	___High Blood Pressure	___Kidney Problems	___Suicide
___Lung Problems	___Overweight	___Psychological Difficulties	___Stroke
___Skin Problems	___Liver Problems	___Rheumatoid Fever	___Diabetes
___Tuberculosis	___Heart Attack	___Venereal Disease (AIDS, herpes, syphilis, etc)	___Other

FAMILY MEDICAL HISTORY

	Age	Health Problems	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Brother(s) and Sister(s)				
Children				

MISCELLANEOUS

What questions do you have that you would like answered?

_____

_____