

1. What is your full name?

First (given) Name	Middle Name:	Family Name:

2. What is your address?

(Street and Number)		(Apt/Unit #)
(City/Town)	(Province)	(Postal code)

3. What is your telephone number?

Home:
Work/Alternative:

4. Who is your Family Doctor? _____ Phone#: _____

Health Card Information

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5. What is your date of birth?

(Month)	(Day)	(Year)
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6. Are you RIGHT or Left handed?

7. Are you SINGLE, MARRIED, SEPERATED, DIVORCED or WIDOWED?

8. Do you have any children?

8a. If yes, how many children do you have?

8b. What are their ages?

8c. Are they all Healthy?

9. Are you a, Student/Worker/Retired?

10. Have you traveled outside of North America recently?

10a. If yes, where did you go?

11. Do you smoke?

11a. If yes, how much do you on average smoke in a (1) day?

11b. If you have in the past, how long ago did you quit?

12. Do you drink alcoholic beverages?

12. If yes, how much would you say you drink on average? (week, month, year)

12b. If you have in the past and have stopped, how long ago did you stop?

12c. Have you ever had a drinking problem?

13. Do you use non-medical street drugs? (Such as marijuana/cocaine)

Some Questions about your Medical History

14. Have you ever had any of the following ailments?

- a) Diabetes - type
- b) High blood pressure
- c) Heart problems
- d) Tuberculosis
- e) Cancer - type
- f) Hepatitis (A, B, C)
- g) Jaundice
- h) Venereal Disease / HIV
- i) Kidney Disease / Stones
- j) Thyroid problems
- k) Pancreatitis
- l) Mental Illness
- m) Rheumatic fever
- n) Scarlet fever
- o) Glaucoma
- p) Asthma
- q) Blood disorder
- r) Other

Yes/No	Date Of Diagnosis

(other including, seizures, arthritis, gynecological problems, gal bladder surgery etc.)

15. Do you have any allergies to food/medicines/etc? If so please list them and the reaction if any, they cause.

Allergies	Reaction

16. Have you ever been hospitalized?
If so, then When?

Which Year (about)?	For what reason?	Which Hospital?	Treatment?

17. Have you ever had a major car accident? One in which you needed to be taken to the hospital?

Year (roughly)	Accidental Injury	Treatment/Test performed

18. Please List all Medication you are currently on.

Drug Name:	Dosage:	How many time a day?	How long have you been on this drug?

19. Have you had any recent changes or problems with:

- a) Fatigue
- b) Sleeplessness
- c) Sweating at night
- d) Fevers
- e) Ability to tolerate cold
- f) Ability to tolerate heat
- g) Increased thirst
- h) Changes in shoe size or glove size
- i) Changes in skin colour
- j) Skin rashes
- k) Skin itchiness
- l) Chest pains
- m) Shortness of breathe
- n) Cough
- o) Wheezing
- p) Coughing up secretions (phlegm)
- q) Coughing up blood
- r) Palpitations
- s) Heart murmur
- t) Ankle swelling
- u) Calf pain
- v) Easy bruising
- w) Increased appetite
- x) Loss of appetite

- y) Headache
- z) Weight gain
- aa) Weight loss
- bb) Indigestion
- cc) Pain in the abdomen (stomach)
- dd) Nausea
- ee) Vomiting
- ff) Diarrhea
- gg) Constipation
- hh) Change in colour of stool
- ii) Hemorrhoids
- jj) Difficulty passing urine
- kk) Dribbling of urine
- ll) Wetting the bed
- mm) Joint pain, swelling stiffness
- nn) Neck pain
- oo) Back pain
- pp) Difficulty with mobility

If Female:

- a. Problems with period
- b. Miscarriages
- c. Breast lumps
- d. Sexual dysfunction
- e. Previous problems with pregnancy
- f. Are you pregnant now?

If Male:

- a) Impotence
- b) Sexual dysfunction

Finally, some brief questions about the current problem. (the reason you have come to us today)

1. Describe your problem(s) briefly (in a few words)
2. When did this begin?
3. Did it begin gradually or suddenly?
3a) If gradually, how did it progress?
4. Was there anything that you know, that caused it?
5. Is it present all the time or does it come and go?
5a) If it comes and goes, how long does it persist for?

6. Does the problem seem worse at certain times of the day or night?
7. Does anything make it worse or bring it on?
8. Does anything make it better?
9. How does it affect your life (e.g. stops you from working, or going out socially)?
10. If a pain, numbness or weakness etc. exactly where in your body is affected?
11. Are there any people in your family with a similar problem?