DR. E. SLEIGH DR. C. CARLSON-RINK DR. A. EZEBUIRO DR. E. D'SOUZA-CAREY

FAMILY HEALTH CLINIC – Naturopathic & Preventive Medicine

PERSONAL HISTORY

(CONFIDENTIAL: All information in this form remains confidential and will be released only on your written permission)

FULL NAME ______________________ BIRTHDATE month/day/yr ____/____/____ AGE ______

NAME YOU PREFER TO BE CALLED ______________ SEX ________ MARITAL STATUS S M CL D W

ADDRESS ______________________ CITY ______________ POSTAL CODE ______________

HOME PHONE ______________ WORK / CELL PHONE ______________EMAIL ADDRESS______________

OCCUPATION ______________ EMPLOYER ______________

FOR APPOINTMENT REMINDERS, HOW WOULD YOU PREFER TO BE CONTACTED? PHONE (Home / Cell): ___________ EMAIL: ___________

EMERGENCY CONTACT NAME:______________ PHONE# ______________ RELATIONSHIP: ______________

FAMILY PHYSICIAN ______________ CHIROPRACTOR______________ SPECIALIST ______________

WHO REFERED YOU TO THIS OFFICE?

PRESENT HEALTH PROBLEMS: LIST YOUR MAIN HEALTH CONCERNS / SYMPTOMS

1) ______________________ WHAT TREATMENTS HAVE BEEN TRIED? ______________

2) ______________________ ______________________

3) ______________________ ______________________

MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING ? (CIRCLE)

ANEMIA	RHEUMATIC FEVER	HEART ATTACK
HEPATITIS/LIVER DISEASE	KIDNEY STONES	HIGH BLOOD PRESSURE
HAYFEVER	ASTHMA	PNEUMONIA
TUBERCULOSIS	CANCER OF__________	BLADDER/VAGINAL INFEC.
STOMACH ULCER	MIGRAINE HEADACHES	ABNORMAL PAP TEST
MEASLES	MUMPS	PROSTATE PROBLEMS
COLITIS	ARTHRITIS/RHEUMATISM	BLEEDING TENDENCIES
BLOOD CLOTS	HIVES	MONONUCLEOSIS
GALLBLADDER PROBLEMS	THYROID PROBLEMS	SEXUALLY TRANSMITTED DISEASE
ANGINA/CHEST PAIN	HEART DISEASE	
POLIO	DIABETES	ECZEMA
STROKE	ALCOHOL/DRUG ABUSE	DEPRESSION
EPILEPSY	MENTAL DISORDER	EATING DISORDER
SMOKER? (Y OR N)		

SURGERIES (YEAR & TYPE) ______________________

____

____

HOSPITALIZATIONS (YEAR & REASON) ______________

____

____

INJURIES/ACCIDENTS (YEAR & CAUSE) ______________

____

OTHER CONDITIONS ______________________

FAMILY HISTORY: INCLUDE BLOOD RELATIVES ONLY

FATHER (age)* __________ BROTHERS (ages)* ______________

MOTHER (age)* __________ SISTERS (ages)* ______________

* If deceased, Please list age at death and circle.

HAVE ANY OF THE ABOVE HAD THE FOLLOWING ? (CIRCLE)

DIABETES	KIDNEY DISEASE	STOMACH ULCERS
HEART DISEASE	ASTHMA	HIGH BLOOD PRESSURE
ALLERGIES	ARTHRITIS	NERVOUS BREAKDOWN
GOUT	COLITIS	BLEEDING TENDENCIES
ALCOHOLISM	TUBERCULOSIS	PSYCHIATRIC ILLNESS
CANCER	STROKE	GALLBLADDER PROBLEM

WOMEN ONLY - CHILDBIRTH HISTORY

NUMBER OF CHILDREN __________ AGES ______________

NUMBER OF PREGNANCIES __________ DELIVERIES____________

MISCARRIAGES _______ ACCIDENTAL _______ INDUCED________

COMPLICATIONS ______________________

BIRTH CONTROL METHODS: IN PAST ______________

NOW ______________

ARE YOU PREGNANT AT THIS TIME ? ______________

KNOWN ALLERGIES (include medicines, pollens, animals, foods & chemicals): ______________

____

____

CURRENT MEDICATIONS (list all prescription & over the counter medicines, **vitamins, minerals, herbs** that you take): ______________

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