PATIENT HISTORY PROFILE

Patient Name: _____
Address: _____
Phone #: _____ Cell #: _____ E-mail: _____
Health Card Number: _____
Date of Birth: Year _____ Month _____ Day _____ Age _____
Family Doctor: _____ Doctor's Phone Number: _____
Doctor's Fax: _____ Doctor's E-mail: _____
Height: _____ BMI: _____

	Yes/No		Date
Reg. Exercise	( )	( )	
Drugs	( )	( )	
Smoking	( )	( )	
Alcohol	( )	( )	
Last Physical	( )	( )	_____
PAP/PSA	( )	( )	_____
Mammogram	( )	( )	_____

PAST HISTORY/RISK FACTORS:

Have you ever had or do you have?

	Yes	No
High blood pressure	( )	( )
Diabetes	( )	( )
High cholesterol	( )	( )
Heart disease/heart murmur	( )	( )
Thyroid problems	( )	( )
Kidney disease	( )	( )
Liver disease/hepatitis	( )	( )
Gout/high uric acid	( )	( )
Anemia	( )	( )
Blood transfusions	( )	( )
GI problems/ulcer/abdominal disease	( )	( )
Respiratory problems/asthma	( )	( )
Skin disease	( )	( )
Headaches/migraines	( )	( )
Muscoskeletal	( )	( )
Osteoporosis	( )	( )
Rheumatoid	( )	( )
Chronic fatigue/FMR	( )	( )
Hormonal problems	( )	( )
Psychiatric problems	( )	( )
Epilepsy	( )	( )
Chest pain	( )	( )
Shortness of breath	( )	( )
Recent cough/cold	( )	( )

Please list previous operations and/or any ongoing medical problems, as well as dates if known:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Occupation: _____
Hobbies: _____
Special dietary needs: _____
Allergies: _____
_____

LONG-TERM TREATMENT REGIMEN:

Please list all the medications you are currently taking
(including recent aspirin/tylenol, blood thinners, birth control pills, blood pressure pills, diabetes medications, tranquilizers, steroids/cortisone, heart pills), as well as any reactions you had:

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Please List the Major Illnesses in Close Family Members (e.g. diabetes, heart disease, high blood pressure, thyroid, cancer, kidney, liver, cholesterol, obesity, etc.):

Father: _____
Mother: _____
Brother/Sister: _____
Grandparents: _____
Children: _____