alta vista naturopathic clinic
Family Preventative Medicine

Dr. Anita Bratt, ND

Health History Questionnaire

By completely filling out this form you will help us to help you. All answers will be *absolutely confidential*. If you have any questions please ask. Thank you.

Name_____ Age _____ □ M □ F Today's Date _____
Your Care Card Number_____ Date of birth (D/M/Y)____/____/_____
Home Address_____
City_____Province_____ Postal Code _____
Email Address_____Occupation _____
Home Phone _____ Work Phone _____
Spouse's Name_____ Children (Name/Age)_____
_____

Healthcare Providers:
Medical Doctor(s) _____ Naturopathic Doctor_____
Chiropractor_____ Other _____

Who referred you to our clinic?
_____

Your Main Health Concern

Please list the reasons for your visit and when the concerns began:
1._____
2._____
3._____
4._____
5._____

Your Past Medical History (Please check and date)

□ Cancer	□ Diabetes	□ STD
□ High Blood Pressure	□ Seizures	□ Heart Disease
□ Hepatitis	□ Rheumatic Fever	□ Thyroid Disease

□ Significant Trauma (auto accidents, falls, other) _____

□ Allergies (drugs, chemicals, foods) List:_____

_____

□ Surgeries/ Hospitalizations. List with dates:

_____

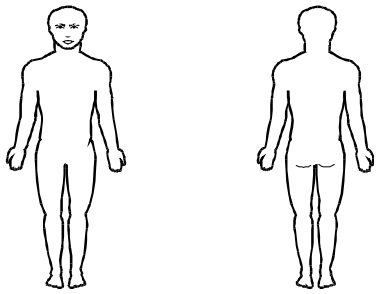
_____

Family Medical History

Please indicate blood relatives, and if on father's (F) or mother's (M) side of the family.

□ Cancer	□ High Blood Pressure	□ Asthma	□ Arthritis
□ Diabetes	□ Heart Disease	□ Allergies	□ Addiction
□ Seizures	□ Stroke	□ Mental illness	□ Tuberculosis

Mark Areas of Concern on the Diagram below:



Please check if the following symptoms are a current or recurring problem.

General

□ Night sweats	□ Weight gain	□ Sweat easily
□ Weight loss	□ Fatigue	□ Chills
□ Fevers	□ Bleed or bruise easily	□ Unusual tastes or smells
□ Excessive thirst	□ Anemia	□ Heat or cold intolerance
□ Sudden energy drop/ time?_____		

Skin and Hair

□ Rashes	□ Change in hair or skin texture	□ Change in moles
□ Itching	□ Loss of hair	□ Ulcers
□ Eczema	□ Dandruff	□ Acne

Head/ Eyes/ Ears/ Nose/ Throat

□ Headaches	□ Night blindness	□ Sinus problems
□ Neck masses	□ Color blindness	□ Nose bleeds
□ Hayfever	□ Cataracts	□ Jaw clicks or pain
□ Eye pain/ strain	□ Earaches	□ Tooth pain
□ Frequent colds/ flus	□ Poor hearing	□ Mercury fillings #_____
□ Blurry vision	□ Ringing in ears	□ Recurrent sore throat
□ Using glasses	□ Facial pain	□ Mouth sores

Heart and Circulation

□ High blood pressure	□ Fainting	□ Cold hands or feet
□ Low blood pressure	□ Chest pain	□ Swelling of hands or feet
□ Irregular heartbeat	□ Varicose veins	□ Dizziness
□ Blood clots		

Respiration

□ Difficulty breathing	□ Asthma	□ Coughing up blood
□ Cough	□ Wheezing	□ Pneumonia
□ Bronchitis	□ Production of phlegm	

Digestion

□ Indigestion/ heartburn	□ Abdominal pain or cramps	□ Rectal pain
□ Gas or bloating	□ Nausea	□ Hemorrhoids
□ Bad breath	□ Vomiting	□ Blood in stool
□ Constipation	□ Chronic laxative use	□ Diarrhea
□ Poor appetite	□ Change in appetite	□ Excessive hunger

Genito-Urinary

□ Frequent urination	□ Unable to hold urine	□ Kidney stones
□ Urgency to urinate	□ Decrease in flow	□ Sores on genitals
□ Pain on urination	□ Distinctive/ odd color	□ Impotency
□ Waking to urinate	□ Blood in urine	

Women

Age of first menses _____ yrs	□ Irregular periods	□ Cramps
Duration of period _____days	□ Heavy flow	□ Light flow
Days between cycles _____days	□ Vaginal discharge	□ Clots
Date of start of last period _____	□ Pelvic pain	□ Breast lumps
Date of last PAP exam _____	□ Breast tenderness	□ Nipple discharge

Any abnormal PAPs? □ No □ Yes

Do you perform a monthly self-breast exam? □ No □ Yes

Any pre-menstrual symptoms? □ No □ Yes. Describe_____

Do you use birth control? □ No □ Yes. What type and for how long? _____

Number of pregnancies_____ Number of births_____ Miscarriages_____ Abortions_____

Musculoskeletal

□ Neck pain	□ Knee pain	□ Muscle pain
□ Back pain	□ Foot/ ankle pain	□ Muscle weakness
□ Hand / wrist pain	□ Hip pain	□ Joint swelling
□ Shoulder pains	□ Joint pain or stiffness	□ Bone pain

Brain/ Nervous System/ Psychological

□ Loss of balance	□ Depression	□ Difficulty concentrating
□ Quick temper/ irritability	□ Susceptible to stress	□ Seizures
□ Poor memory	□ Dizziness	□ Areas of numbness
□ Anxiety	□ Lack of coordination	□ Mood swings
□ Eating disorder	□ Addiction	

Have you ever been treated for emotional problems? □ No □ Yes. Describe_____

Have you ever considered or attempted suicide? □ No □ Yes. When? _____

Any significant life stresses? Describe._____

Personal Habits

Smoker □ No □ Yes # Years smoked _____ Amount/day_____
Alcohol Use: □ No Yes Type & amount _____
Recreational drug use: □ No □ Yes Type & amount _____
□ Coffee cups/day _____ □ Tea cups/day _____ □ Cola cups/day _____

Do you exercise regularly? □ No □ Yes
Type(s) of activity_____How often/long? _____

Height _____ Weight_____ lbs Maximum weight _____when(year)?_____

Sleep

□ Good □ Difficulty falling asleep □ Frequent waking □ Nightmares
Time to bed: _____ Wake at:_____ Refreshed in morning? □ No □ Yes

Current Medications

List all prescriptions, over-the-counter drugs, and vitamins/supplements. Please include doses.
1)_____ 5)_____
2)_____ 6)_____
3)_____ 7) _____
4)_____ 8) _____

Diet

□ Are there any foods that you avoid or restrict? _____

□ Do you crave any foods? _____
Bowel movements #/day _____

Please describe your average daily diet:
Breakfast: _____

Lunch:_____

Dinner: _____

Snacks: _____

Drinks: _____

Comments

Please describe any other problems you would like to discuss.