



West Vancouver Wellness Centre

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www.healthydoc.com

Health History Questionnaire

Please help us provide you with a complete evaluation by carefully filling out this questionnaire. All of your answers will be held *absolutely confidential*. If you have questions, please ask. Thank you.

Name _____ Age _____ M F Today's Date (Mo/Day/Year) _____
E-Mail Address _____ Birth Date (Mo/Day/Year) _____
Home Address _____ City _____ Postal Code _____
Occupation _____ Work Phone _____ Home Phone _____
Spouse's Name _____ Children (Name/Age) _____

If the above is a child: Father's Name _____ Names of Other Healthcare Providers:
Mother's Name _____ Naturopathic Physician _____
Who referred you to our clinic? _____ Massage Therapist _____
Medical Doctor _____
Chiropractor _____
Number of visits to another Naturopathic Physician this year _____ Specialist _____

CURRENT HEALTH CONCERN(S)

When did your problem(s) begin (be specific)? _____

Have you been given any diagnosis? If so, what? _____

What measures have you taken to improve your problem(s)? _____

CURRENT MEDICATIONS (Prescriptions, Over the Counter Drugs, Nutritional supplements)

1) _____ Dosage: _____	6) _____ Dosage: _____
2) _____ Dosage: _____	7) _____ Dosage: _____
3) _____ Dosage: _____	8) _____ Dosage: _____
4) _____ Dosage: _____	9) _____ Dosage: _____
5) _____ Dosage: _____	10) _____ Dosage: _____

YOUR PAST MEDICAL HISTORY (please circle and include date)

Significant Illnesses: Cancer Diabetes Hepatitis High Blood Pressure Heart Disease
Rheumatic Fever Seizures Thyroid Disease Venereal Disease Other

Surgeries(date): _____

Significant Trauma (auto accidents, falls, etc.) _____

Your Birth (prolonged labour, forceps delivery, etc.) _____

Allergies (drugs, chemicals, environmental, foods) _____

FAMILY MEDICAL HISTORY ← _____

Please indicate family member and Mother's side (M) or Father's side (F)

Allergies

Asthma

Arthritis

Autoimmune disease

Cancer

Diabetes

Heart Disease

High Blood Pressure

Kidney Disease

Seizures

Stroke

Tuberculosis

Other

OCCUPATIONAL STRESS (chemical, physical, psychological) ← _____

DESCRIBE YOUR WEEKLY EXERCISE ← _____

DIET ← _____

Are you vegetarian or vegan, if so please specify?

Are you or have you ever been on a restricted diet? What kind?

Please describe your average daily diet:

Morning

Afternoon

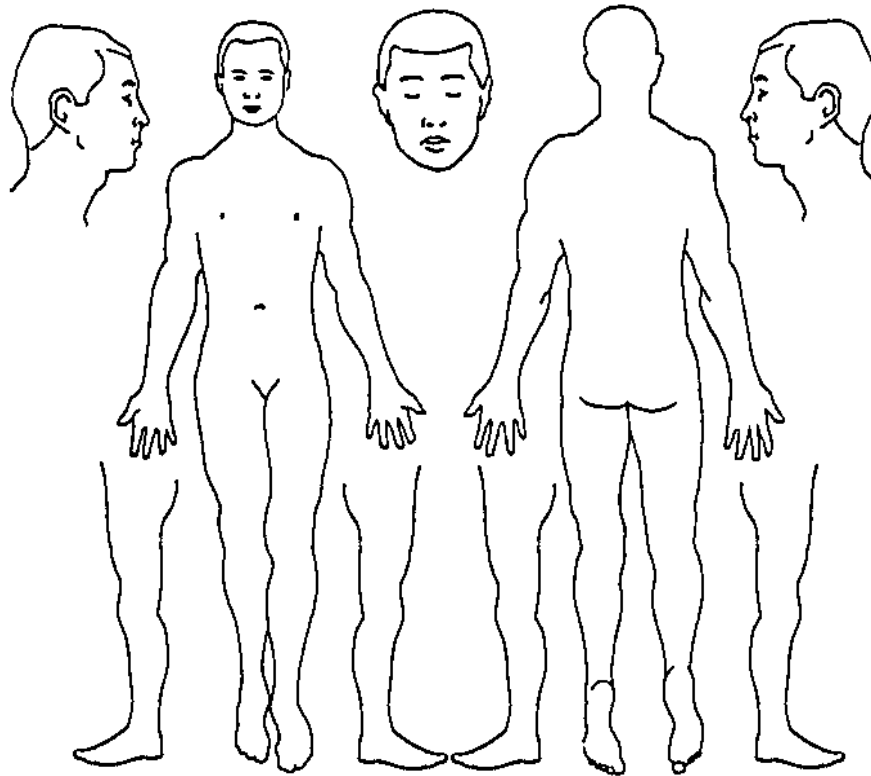
Evening

How many cigarettes do you smoke a day?

How much coffee, tea or cola do you drink per week?

How much alcohol do you drink per week?

INDICATE PAINFUL OR DISTRESSED AREA ←



Please check if the following symptoms are currently a problem or are a recurring problem:

GENERAL ←

- | | | |
|---|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Strong thirst (cold or hot drinks) | |
| <input type="checkbox"/> Sudden energy drop (what time of day)? | | |

SKIN AND HAIR ←

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Any other hair or skin problems? | |

HEAD, EYES, EARS, NOSE AND THROAT ←

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Colour blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Headaches (where and when)? |

CARDIOVASCULAR ←

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty in breathing |
| <input type="checkbox"/> Any other heart or blood vessel problems? | | |

RESPIRATORY ←

- | | | |
|--|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with a deep breath |
| <input type="checkbox"/> Difficulty in breathing when lying down | <input type="checkbox"/> Production of phlegm (what colour)? | |
| <input type="checkbox"/> Any other lung problems? | | |

GASTROINTESTINAL ←

- | | | |
|--|---|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Black stools |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Belching | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Chronic laxative use | |
| <input type="checkbox"/> Any other problems with your stomach or intestines? | | |

GENITO-URINARY ←

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Decrease inflow | <input type="checkbox"/> Impotency | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Do you wake to urinate (how often)? | <input type="checkbox"/> Any particular colour to your urine? | |
| <input type="checkbox"/> Any other problems with your genital or urinary system? | | |

PREGNANCY AND GYNECOLOGY ←

- | | | |
|---|---|--|
| <input type="checkbox"/> Age at first menses | <input type="checkbox"/> Number of births | <input type="checkbox"/> Premature births |
| <input type="checkbox"/> First date of last menses | <input type="checkbox"/> Abortions | <input type="checkbox"/> Number of pregnancies |
| <input type="checkbox"/> Days between menses | <input type="checkbox"/> Duration of menses | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Unusual menses 0 Heavy | <input type="checkbox"/> Light | <input type="checkbox"/> Clots |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Last PAP |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Changes in body / psyche prior to menstruation | | |
| <input type="checkbox"/> Do you practice birth control? What type and for how long? | | |

MUSCULOSKELETAL ←

- | | | |
|---|--|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Foot/ ankle pain |
| <input type="checkbox"/> Hand/ wrist pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Joint or bone problems |

NEUROPSYCHOLOGICAL ←

- | | | |
|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Quick temper / irritable | <input type="checkbox"/> Easily susceptible to stress | |
| <input type="checkbox"/> Have you ever been treated for emotional problems? | | |
| <input type="checkbox"/> Have you ever considered or attempted suicide? | | |
| <input type="checkbox"/> Any other neurological or psychological problems? | | |

COMMENTS ←

Please indicate any other problems you would like to discuss.