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ADULT PATIENT HEALTH HISTORY

Your careful consideration of each of the following questions will enhance our use of your scheduled consultation time. Please note that this form will be discussed in detail in your first visit and that all of the information in this form will be kept in strict confidence.

Date: _____
First Name: _____ Last Name: _____
Occupation: _____ Birth date:_____/_____ Gender: _____

How did you hear about our clinic:

Other Healthcare providers you are seeing: (please give name, type of practitioner/specialist, and contact information if you can)

1.	2.	3.

Please fill in the following pages as best you can.

Primary Problem: (this will be discussed in detail in your first visit)

Other health concerns, in order of importance to you:

1	
2	
3	
4	

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Medications and Allergies

Current Medications: (prescription and non-prescription ex: Tylenol)	Dose:	Duration:	Reason for Taking / Results Experienced

Current Vitamins/Herbs/ Supplements:	Dose:	Duration:	Reason for Taking / Results Experienced:

Do you have any known **allergies** or drug sensitivities?

Number of times on antibiotics in past 10 years: _____

Number of times on corticosteroids in past 10 years: _____ Topical? ☐ Oral? ☐

Please check any of the following medications you are taking or have taken in the past 2 years:

- ☐ Aspirin/Tylenol
- ☐ Antacids
- ☐ Radiation
- ☐ Pain Relievers
- ☐ Laxatives
- ☐ Chemotherapy
- ☐ Sleeping Pills
- ☐ Diuretics
- ☐ Epi Pen
- ☐ Tranquilizers
- ☐ Birth Control
- ☐ Appetite Suppressants

Personal Medical History

Current Height: _____' _____" Weight:_____

Frequent childhood infections? ☐ Yes ☐ No Frequent childhood antibiotic use? ☐ Yes ☐ No

Any complications?

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Any chronic problems as a child? (lungs, stomach, throat, ears, allergies etc..)

Specific teenage problems? (acne, weight, development, mono, etc.)

Adult Illnesses (Active? Resolved?)	Age:	Duration:	How Severe? (Hospitalized?)	Current Status?

When did you notice changes to your health?

Do you smoke? ☐ yes ☐ no How many cigarettes per day? _____

Does anyone in your household smoke? ☐ yes ☐ no

Psychosocial History

List any important life experiences in chronological order, especially traumatic events:

Event:	Age:	Comment:

Have you ever had a nervous breakdown? ☐ yes ☐ no

If yes, please describe the circumstance

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Who are the most significant others in your life and what are the challenges in each relationship:

Family History

Health problems of mother:

Heath problems of father:

Please check any diseases which have occurred in your family, who had them and at what age.

	Who / Age		Who / Age
☐ Cancer (type)		☐ Kidney Disease	
☐ Hypertension		☐ Diabetes	
☐ Arthritis		☐ Obesity	
☐ Heart disease		☐ Anaemia	
☐ Stroke		☐ Mental illness	
☐ Autoimmune		☐ Osteoporosis	
☐ Thyroid Disease		☐ Alcoholism	
☐ Intestinal Disease		☐ Other	

Thank you for taking the time to fill out the health history form. Please print and bring with you to your first appointment.

Alternatively, you can click "submit" and email it directly to Whole Medicine Wellness Centre.

PRINT