

Dr Serenity Aberdour ND
Naturopathic Physician

PATIENT INFORMATION AND HEALTH HISTORY

Name_____ Age____ Birthdate_____ M F
Today's date_____

Address_____ City_____ Province_____
Postal Code_____

Home phone_____ Work phone_____
Fax_____ Email_____

Occupation_____

Marital Status_____

Emergency Contact: Name_____ Relation_____

Number_____

How did you learn about this clinic?_____

Have you had previous treatment by a naturopathic doctor? Y N

If yes when?_____

Other Health Care providers:

MD_____

DC (chiropractor)_____

Other(s)_____

MAIN HEALTH CONCERNS

Please list your major health concerns at this time

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

When did these complaints begin?_____

What other treatment(s) have you received for these complaints?_____

Have any specialists been consulted regarding these complaints? Y N

Please list your current prescription medications_____

HEALTH HISTORY

Please list all prescription medication that you have used in the last 2 years

Please list all non-prescription medications that you currently use (include all over the counter products, herbal medicines and supplements) and dosage.

Please list any known allergies to:

- 1) Medications _____
- 2) Foods _____
- 3) Plants/environment/animals _____

When was your last complete physical exam? _____

When was your last dental exam? _____

Women only When was your last PAP exam _____

- Are you pregnant? Yes No
- Are you breast feeding? Yes No
- Number of pregnancies? _____
- Number of live births? _____
- Age of first period? _____
- Are your periods regular? Yes No
- Do you do regular self breast exams? Yes No
- Do you use birth control pills? Yes No

Please list any major illnesses/injuries/ surgeries/hospitalisations and their approximate dates:

- Are you HIV positive? Yes No
- Have you been diagnosed with hepatitis? Yes No

Do you smoke? **Y** **N** If yes, how much do you smoke per day _____

Number of alcoholic beverages consumed per week _____

Number of caffeinated beverages (tea/coffee/pop) per day _____

Hours of sleep per night _____

Please indicate which of the following disorders you have experienced

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Herpes | <input type="checkbox"/> complaints |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High blood | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> pressure | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hives | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> (please specify): |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Kidney disease | |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of | <input type="checkbox"/> Sunstroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> consciousness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Malaria | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Goitre | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Parasites | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Heart disease | | |

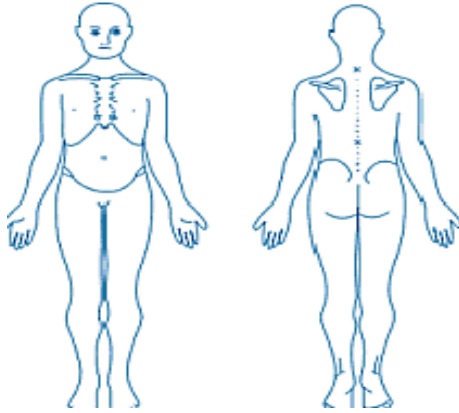
Please list family members who do/have had any of the following complaints

- | | |
|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Other mental disorders (please | <input type="checkbox"/> Chronic digestive tract |
| specify): | complaints |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Substance abuse/addiction |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Birth defects |

Please indicate which of the following symptoms/complaints you have currently or have had in past few months:

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Waking at night to urinate |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Unable to hold urine |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Cold hand/feet | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irregular heart beat/palpitations | <input type="checkbox"/> Joint pain (please specify): |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> Muscle pains (specify part(s) of body): | <input type="checkbox"/> Low blood pressure | |
| | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Sweating easily/excessively | <input type="checkbox"/> Gas/bloating | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Weight gain/ loss | <input type="checkbox"/> Constipation | <input type="checkbox"/> Menstrual pain |
| <input type="checkbox"/> Changes in thirst or appetite | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Easy bleeding or bruising | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Heavy Menses |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Regular use of laxatives | <input type="checkbox"/> Absence of menses |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Abdominal pain/cramps | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Itching (specify body part): | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Breast pain |
| | <input type="checkbox"/> Haemorrhoids | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Frequent/urgent urination | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Pain on urination | |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Impotence | |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Blood in urine | |
| <input type="checkbox"/> Poor hearing | | |
| <input type="checkbox"/> Fainting | | |

Please indicate Painful or distressed areas:



What are the major stressors in your life?

How do you cope with the stress in your life?

Do you exercise regularly?

If yes, describe typical exercise per week

Diet

Please describe your food intake over the past 24 hours:

Are you currently following a specialized/ restricted diet?

Additional Information:

Please add any additional information about yourself and/or your health that you feel is important (please use the back of this page if more space is required)