CONFIDENTIAL PATIENT HEALTH RECORD

A. Personal History

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal: _____

Home Phone: _____

Work/Cell: _____ PHOTO

Email: _____

Birth date: mm___dd____yyyy_____Age: _____

Height: _____ Weight: _____

Occupation: _____

Number of children:____Miscarriages:____ Dependents: ____

Referred to this office by: _____

Check one: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Common-law

Who is responsible for your bill? You and: ☐ Private (you only) ☐ Extended Medical Plan ☐ MSP ☐ ICBC ☐ WCB

If you receive premium assistance, please provide us with your MSP #: _____

B. Current Health Condition

Purpose of this appointment: _____

Major complaint: _____

Other doctor's seen for this condition: _____

When did this condition begin? _____

Are there others in your family with this same condition? _____

If disabled from work please give dates: _____

Date of accident/ injury: _____ ☐ Job related ☐ Auto Related

Medication you now take: ☐ Nerve Pills ☐ Pain killers/Muscle relaxants

☐ Blood Pressure ☐ Insulin ☐ Aspirin/Similar ☐ Other _____

Do you suffer from any conditions other than that for which you are now consulting us? _____

_____

C. Past Health History (Please check or describe)

Major surgery operations: ☐ Appendix ☐ Tonsils ☐ Gall Bladder ☐ Back

☐ Hernia ☐ Heart ☐ Neck ☐ Leg ☐ Other _____

Major accidents or falls: _____

Hospitalization (other than above): _____

Previous care: Doctor's name and approximate date of last visit: _____

Have you been treated for any health condition in the last year? ☐ Yes ☐ No

If yes, please explain: _____

Does anyone else in your family have the same or similar condition? _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course.

Check any of the following diseases you have had:

☐ Pneumonia	☐ Mumps	☐ Influenza	☐ Hepatitis
☐ Rheumatic Fever	☐ Small Pox	☐ Pleurisy	☐ HIV/ Aids
☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Epilepsy
☐ Tuberculosis	☐ Diabetes	☐ Whooping cough	☐ Cancer
☐ Mental disorder	☐ Anemia	☐ Heart disease	☐ Lumbago
☐ Measles	☐ Thyroid	☐ Eczema	

Intake:
- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Check any of the following you have had in the past six months:

MUSCULO-SKELETAL CODE
- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain/ stiffness
- ☐ Walking problems
- ☐ Difficult chewing/ clicking jaw
- ☐ General stiffness

NERVOUS SYSTEM CODE
- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confused/ Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/ tingling extremities
- ☐ Stress

GENERAL CODE
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE
- ☐ Poor/ excessive appetite
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gall bladder problems
- ☐ Weight problems
- ☐ Abdominal cramps
- ☐ Gas/ bloating after meals
- ☐ Heartburn
- ☐ Black/ bloody stool
- ☐ Colitis

GENITO-URINARY CODE
- ☐ Bladder trouble
- ☐ Painful/ excessive urination
- ☐ Discolored urine

EENT CODE
- ☐ Vision problems
- ☐ Dental problems
- ☐ Sore throat
- ☐ Earaches
- ☐ Hearing difficulty
- ☐ Stuffed nose

C-V-R CODE
- ☐ Chest pain
- ☐ Short breath
- ☐ Blood pressure problems
- ☐ Irregular heartbeat
- ☐ Heart problems
- ☐ Lung problems/ congestion
- ☐ Varicose veins
- ☐ Ankle swelling
- ☐ Stroke

MALE/FEMALE CODE
- ☐ Menstrual irregularity
- ☐ Menstrual cramping
- ☐ Vaginal pain/ infections
- ☐ Breast pain/ lumps
- ☐ Prostrate/ sexual dysfunction
- ☐ Genital herpes

Females only:

When was your last period?

_____

Are you pregnant?

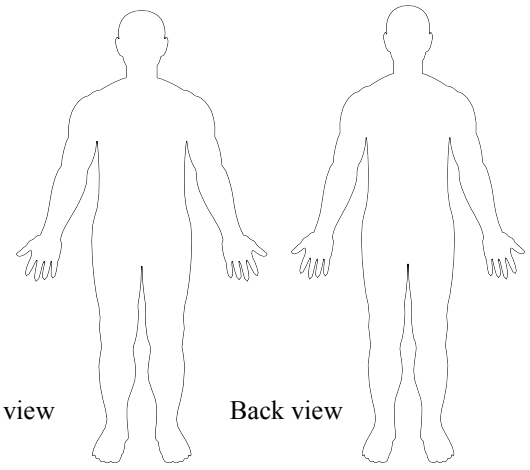
☐ Yes ☐ No ☐ Unsure

Habits:

	Heavy	*Moderate*	*Light*	*None*
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

Do you currently take vitamins or minerals? ☐ Yes ☐ No

Do you think you may need to take vitamins or minerals? ☐ Yes ☐ No



Front view Back view

Please outline on the diagram the area of your discomfort.

DO NOT WRITE BELOW THIS LINE

Diagnosis:

Patient accepted: ( ) Yes ( ) No ( ) Referred

_____

Doctor's Signature