Patient Health Summary

File Number:\_\_\_\_\_\_\_\_\_

 ***Clinic Name/Practitioner Name/Registration #***

***Clinic Address/Clinic Telephone Number***

|  |
| --- |
| **Patient Information** |
| First Name:  | Last Name: | Middle Name: |
| Telephone (Home/Mobile): Telephone (Business): | Sex: M / F / Other |
| Home/Street Address: |  |  Apt #: | Date of Birth: (DD/MM/YY) |
| City: |  Province: |  Postal Code: | Marital Status: |
| Occupation: | Email: |
| Family Contact Information | First name: | Last name: |
| Relationship to Patient: | Phone Number: | Mobile Number: |
| Emergency Contact information (If different individual from above) | First name: | Last Name: |
| Relationship to Patient: | Phone Number: | Mobile Number: |
| Family Doctor Name: |
| Clinic Address: |  |  |  |
| Clinic Phone: |  | Clinic Email: |  |
| **Past Medical History** |
| *Please list any relevant past medical history including any hospitalizations, surgeries, prior injuries, or any past medical conditions etc. Be sure to include any previous family medical conditions or diseases that may be relevant.* |
| **Ongoing Health Conditions/ Allergies/Drug Reactions/ Risk Factors/Long Term Treatment** |
| *Please list any ongoing health conditions, allergies, drug reactions, and long term treatments that may be relevant. If you are currently taking any prescription medications, please include them.* |

**Please circle any conditions you are experiencing (past and present):**

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| --- | --- | --- | --- |
| **General Symptoms** | **Cardiovascular** | Dental decay | Colitis |
| Headaches/migraines | High or low blood pressure | Gum trouble | Hemorrhoids |
| Fever | Previous stroke or TIA | Frequent colds | Hypoglycemia |
| ChillsSweat | High cholesterol | Enlarged thyroid | Hiatal hernia |
| Memory loss | Swelling of ankles | Tonsillitis | Metallic taste |
| Dizziness/Light headiness | Poor circulation | Sinus infection |  |
| Fainting | Stroke/heart attack | Nasal drainage |  |
| Stress/depression | Irregular heart beat | Enlarged glands |  |
| Discoordination | Shortness of breath |  |  |
| Nervousness | Pain over heart |  | **For Women Only** |
| Recent weight loss/gain |  | **Skin** | Cramps/backache |
| Numbness pain in arms, legs |  | Skin conditions/rashes | Previous miscarriage |
|  | **Genitourinary System**Frequent/painful urination | ItchingBruise easily | Irregular cycleVaginal discharge |
|  | Blood in urine/stool | Dryness | Lumps in breast |
| **Respiratory**Wheezing | Mucus in stoolKidney infection/kidney stone | BoilsVaricose veins | Menopausal symptoms |
| Chronic cough | Bladder infection | Sensitive skin | Pregnant |
| Spitting up phlegm | Inability to control urine | Hives or allergy | Painful menstruation |
| Chest pain |  |  | Excessive flow |
| Difficulty breathing |  |  | Hot flashes |
|  | **Ears, Eyes, Nose, Throat** | **Gastrointestinal**Poor appetite | Hysterectomy |
| **Muscle and Joint** | Hearing lossVision problemsGlaucoma | Distress from greasy foods |  |
| Stiff neckBack ache | Ringing in ear(s)Crossed eyes | Excessive hunger/thirst |  |
| Swollen joints | Eye pain | Belching or gas |  |
| Painful tailbone | Deafness | Nausea |  |
| Pain in shoulder | Earache | Vomiting |  |
| Hernia | Ear discharge | Burning in stomach |  |
| Spinal curvature | Nose bleeds | Pain over stomach |  |
| Faulty posture | Nasal obstruction | Constipation/diarrhea |  |
| Arthritis | Sore throat | Colon trouble |  |
| Foot trouble | Hoarseness | Liver trouble/hepatitis |  |
|  | Hay fever | Gall bladder |  |
|  | Asthma | Ulcers |  |

**Have you had any of the following?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Appendicitis | Malaria | Chicken pox | Alcoholism | Osteoporosis |
| Diabetes | Venereal infection | Cold sores | Whooping couch | Cancer |
| Epilepsy | Multiple sclerosis | Anemia | Heart disease | Tuberculosis |
| Pneumonia | Measles | Goiter | Eczema | Mental illness |
| Mumps | Influenza | Gout | Polio | Pleurisy |
| Pneumatic fever | Arthritis | Rubella | Parkinson’s  | HIV/AIDS |
|  |  |  |  |  |

**Signature of Patient: or Substitute Decision-Maker:**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**