

KAMLOOPS NATUROPATHIC CLINIC Ltd.
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HEALTH HISTORY QUESTIONNAIRE - MALE

Date: _____

(All information is held absolutely CONFIDENTIAL)

Name: _____ P.H.N: _____
(Care Card Number)

Birth Date: _____ Age: _____ M or F (Circle Please)

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Email Address: _____ Occupation: _____

Emergency Contact Information:

Name: _____ Relationship to you: _____

Contact Numbers: _____

Names of other Healthcare Providers:

Are you currently under the care of another Physician? _____

Are you currently taking any medications? Please list: _____

Are you currently on any supplements or remedies? Please list: _____

How did you hear about our clinic? _____

What are your main concerns today and when did they begin?

Have they been diagnosed? _____

Have there been any improvements made? _____

Past/Recent Surgeries? _____

Past/Recent Trauma (Physical and emotional)?

Do you have any allergies? _____

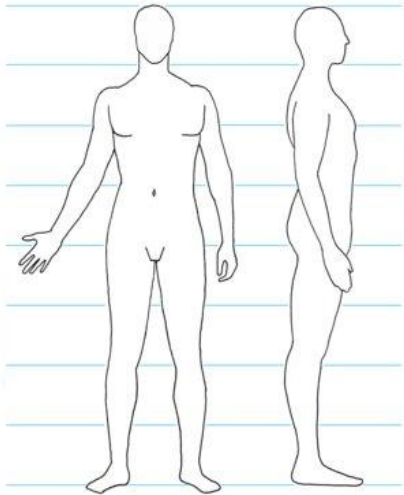
Please indicate any other problems you would like to discuss:

Exam and Imaging History

Indicate date, doctor's name, or place of most recent tests

Physical Exam		HIV test	
Prostate Exam		Chest X-ray	
Digital Rectal Exam		EKG	
Colonoscopy		STD Screen	
TB test		Cholesterol test	
Bone density test		Blood glucose	
Other physical exam		Urinalysis	
Other imaging test		Fecal Occult Blood	
Any Other test		Other blood test	

INDICATE ANY PAINFUL OR DISTRESSED AREAS:



Family Medical History

Has any family member had:	Yes	Which Relative and Age of Onset?	Doctor's Notes
Diabetes			
Severe allergies			
Stroke			
Heart Disease			
Heart Attack			
Blood Clots in Legs or Lungs			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Osteoporosis			
Hepatitis			
Thyroid Problems			
Colitis / Crohn's Disease			
Tuberculosis			
Has any family member had:	Yes	Which relative and Age of Onset?	Doctor's Notes
Birth Defects			
Alcohol or Drug Addiction			
Breast Cancer			
Colon Cancer			
Ovarian Cancer			
Uterine Cancer			
Other Cancer			
Mental Illness/Depression			
Alzheimer's Disease			
Other:			

Lifestyle and Social History

Habits	Yes	No	Details	Doctor's Notes
Current Tobacco Use			Packs per day:	
Past Tobacco Use			Packs per day:	
Quit Smoking			When?	
Alcohol consumption			Types: Drinks per week:	
Recreational Drug Use			Type:	
Treated for drug/alcohol abuse?			When?	
Seat Belt Use				
Caffeine Use (coffee, tea, cola)			Type: Cups per day:	
Regular Exercise			Types: How long and how frequent?	

Social	Yes	No	Details	Doctor's Notes
Happy with relationship status?				
Do you have a good support network of family and friends?			Who?	
What is your predominant emotion?				

Lifestyle
Do you enjoy your work? Yes No
Stress Level (please circle): Low Medium High
Stress Source (please circle): Money Job Family/Relationship Other (please describe)
What do you do to relieve stress?
Please rate your energy level on a scale from 1-10 (10 = highest energy)

Sleep	Yes	No	Details	Doctor's Notes
Problems falling asleep				
Problems staying asleep				
Regular bedtime?			Typical bedtime?	
Regular wake up time?			Typical wake up time?	
Wake rested in the morning?			Average hours of sleep per night?	
Dreams?				

Diet	Doctor's Notes
Do you follow a particular diet?	
Known food allergies/intolerances?	
What is your typical breakfast?	
What is your typical lunch?	
What is your typical dinner?	
Snacks?	
Desserts/Treats?	
How much water do you drink per day?	
What other fluids do you drink and how much per day?	
What is your current weight?	
What was your weight one year ago?	

Review of Systems

Please check if you currently have or have had in the past:

General	Never	Past	Current	Doctor's Notes
Weight loss or gain				
Fever or chills				
Fatigue				
Heat or Cold Intolerance				
Cold Hands and Feet				
Sweats or Night Sweats				
Excessive Thirst				
Skin	Never	Past	Current	Doctor's Notes
Dryness				
Eczema				
Rashes or Itching				
Sores				
Mole changes				
Hair or nail changes				
Easy Bruising				
Head	Never	Past	Current	Doctor's Notes
Headache				
Head Trauma				
Eyes	Never	Past	Current	Doctor's Notes
Blurred Vision				
Glasses or Contact Lenses				
Dry Eyes				
Eye Pain				
Glaucoma				
Discharge from Eyes				
Ears	Never	Past	Current	Doctor's Notes
Earaches				
Ringing in Ears				
Hearing Loss				
Nose	Never	Past	Current	Doctor's Notes
Sinus Congestion or Infection				
Bleeding				
Discharge				
Post Nasal Drip				
Mouth / Throat	Never	Past	Current	Doctor's Notes
Sores				
Bleeding Gums				
Toothaches / Cavities				
Hoarseness of Voice				
Recurrent/persistent sore throat				
Bitter or Metallic Taste in Mouth				
Lungs	Never	Past	Current	Doctor's Notes
Asthma				
Shortness of Breath				
Chest Pain or Tightness				
Persistent Cough				
Wheezing				
Bronchitis				
Emphysema				
Pneumonia				
Tuberculosis				
Cardiovascular	Never	Past	Current	Doctor's Notes
Heart Palpitations/Arrhythmia				
High Blood Pressure				
Low Blood Pressure				
Heart Murmurs				

Cardiovascular, Continued...	Never	Past	Current	Doctor's Notes
Heart Disease				
Heart Attack				
Stroke				
Pacemaker				
Blood Clots in Legs or Lungs				
Swelling (edema) of Feet/Legs				
Circulatory Problems				
Varicose Veins				
Peripheral Arterial Disease				
Gastrointestinal	Never	Past	Current	Doctor's Notes
Loss of or Excess Appetite				
Nausea or Vomiting				
Difficult or Painful Swallowing				
Eating Disorders				
Indigestion or Heartburn				
Ulcer				
Gas / Bloating				
Constipation				
Diarrhea				
Blood in Stool				
Mucus in Stool				
Undigested Food in Stool				
Black or Tarry Stool				
Colitis/ Crohn's Disease				
Hernia				
Hemorrhoids				
Anal Discomfort				
Gallbladder Disease				
Hepatitis (type)				
High Cholesterol / Lipids				
Liver Disease				
Urinary	Never	Past	Current	Doctor's Notes
Pain with Urination				
Increased Urinary Frequency				
Urinary Frequency at Night				
Incontinence				
Urinary Tract Infection				
Kidney Disease				
Musculoskeletal	Never	Past	Current	Doctor's Notes
Muscle Pain / Spasm / Strain				
Joint Pain / Sprain				
Osteoarthritis				
Rheumatoid Arthritis				
Osteoporosis				
Weakness				
Trauma / Swelling				
Endocrine				
Diabetes				
Thyroid Disease				
Tremor				
Hormone Therapy				
Breast Tissue				
Breast Lumps				
Breast Pain				
Nipple Discharge				

Blood / Lymphatic	Never	Past	Current	Doctor's Notes
Anemia				
Bleeding Tendencies				
Blood Transfusion				
Persistent Swollen Lymph Node				
Blood / Lymph Disease				
Allergic / Immune	Never	Past	Current	Doctor's Notes
HIV / AIDS				
Cancer / Chemotherapy				
Autoimmune Disease				
Hay Fever / Asthma / Eczema				
Drug Allergies				
Food Allergies				
Environmental Allergies				
Neurologic				
Epilepsy/ Seizures/Convulsions				
Fainting				
Dizziness or Vertigo				
Problems with Speech				
Problems with Walking				
Problems with Coordination				
Paralysis / weakness				
Neurologic	Never	Past	Current	Doctor's Notes
Numbness				
Multiple Sclerosis				
Psychologic				
Anxiety				
Depression				
Chemical Dependency				
Phobias				
Memory Loss				
Mood Changes				
Psychiatric Care				

Male Health Information

Condition	Never	Past	Current	Doctor's Notes
Testicular Pain / Swelling				
Impotence / Sexual Difficulties				
Prostatitis/Prostate Problems				
Sexually Transmitted Infection				
Genital sores, warts or other lesions?				
Sexually Active				
Practice safer sex practices				
Doctor's Notes:				