KAMLOOPS NATUROPATHIC CLINIC ltd.

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HEALTH HISTORY QUESTIONNAIRE - FEMALE

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? _____

_____

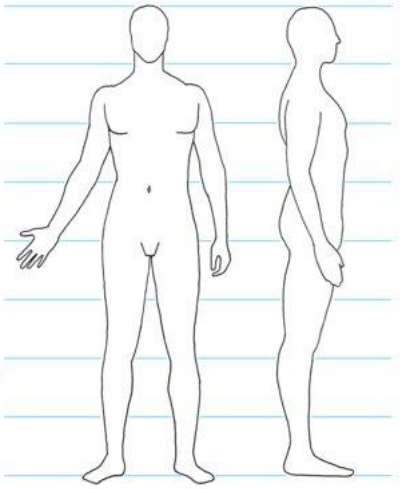
Please indicate any other problems you would like to discuss: _____

Exam and Imaging History

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

Full Physical Exam		**HIV test**	
Pap Smear		**Chest X-ray**	
Mammogram		**EKG**	
Digital Rectal Exam		**STD Screen**	
Colonoscopy		**Cholesterol test**	
TB test		**Blood glucose**	
Bone density test		**Urinalysis**	
Other physical exam		**Fecal Occult Blood**	
Other imaging test		**Other 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**	
Dryness				
Eczema				
Rashes or Itching				
Sores				
Mole changes				
Hair or nail changes				
Easy Bruising				
Head	**Never**	**Past**	**Current**	
Headache				
Head Trauma				
Eyes	**Never**	**Past**	**Current**	
Blurred Vision				
Glasses or Contact Lenses				
Dry Eyes				
Eye Pain				
Glaucoma				
Discharge from Eyes				
Ears	**Never**	**Past**	**Current**	
Earaches				
Ringing in Ears				
Hearing Loss				
Nose	**Never**	**Past**	**Current**	
Sinus Congestion or Infection				
Bleeding				
Discharge				
Post Nasal Drip				
Mouth / Throat	**Never**	**Past**	**Current**	
Sores				
Bleeding Gums				
Toothaches / Cavities				
Hoarseness of Voice				
Recurrent/persistent sore throat				
Bitter or Metallic Taste in Mouth				
Lungs	**Never**	**Past**	**Current**	
Asthma				
Shortness of Breath				
Chest Pain or Tightness				
Persistent Cough				
Wheezing				
Bronchitis				
Emphysema				
Pneumonia				
Tuberculosis				
Cardiovascular	**Never**	**Past**	**Current**	
Heart Palpitations/Arrhythmia				
High Blood Pressure				
Low Blood Pressure				
Heart Murmurs				
Heart Disease				

Cardiovascular, Continued…	**Never**	**Past**	**Current**	
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**	
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**	
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	**Never**	**Past**	**Current**	**Doctor's Notes**
Diabetes				
Thyroid Disease				
Tremor				
Hormone Therapy				
Breast Tissue	**Never**	**Past**	**Current**	**Doctor's Notes**
Breast Lumps				
Breast Pain				
Nipple Discharge				
Blood / Lymphatic	**Never**	**Past**	**Current**	**Doctor's Notes**
Anemia				
Bleeding Tendencies				
Blood Transfusion				
Persistent Swollen Lymph Node				

Blood / Lymphatic continued				
Blood / Lymph Disease				
Allergic / Immune	**Never**	**Past**	**Current**	
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				

Female Health Information

Menstrual History				**Obstetric History**			
Age at first period:				Have you ever been pregnant?			
Date last menstrual period began:				Age at first pregnancy:			
Are your periods regular?				Number of pregnancies:			
Number of days between periods:				Number of living children:			
Number of days of menstrual flow:				Number of stillbirths:			
Heaviness of flow (number of pads or tampons in 24 hours):				Number of miscarriages: Trimester of pregnancy?			
Color of flow:				Number of tubal pregnancies:			
Clots? (please circle)	Yes	No		Number of abortions:			
Pain with menstrual period?	Yes	No		Number of Ceasarian sections:			
Menopause?	Yes	No		Date of last pregnancy:			
Ovarian cyst?	Yes	No		Difficulty conceiving?	Yes	No	
Uterine fibroids?	Yes	No		Difficulty with pregnancy?	Yes	No	
Hysterectomy?	Yes	No	If yes, date:	Difficulty with labor and delivery?	Yes	No	
PMS Symptoms (circle all that apply): None Bloating				Difficulty with breast feeding?	Yes	No	
Breast Tenderness Acne Mood Swings Fatigue				Future OB plans?	Yes	No	
Digestive Changes Headache Other:							

Vaginitis Symptoms	**Never**	**Past**	**Current**	**Risk Factors**		
Discharge				History of abnormal Pap smear?	Yes	No
Irritation / Itching				Did your mother take DES?	Yes	No
Vaginal Dryness				Do you do self-breast exams?	Yes	No
Odor				Do you have annual gynecological exams?	Yes	No
Pain with Sex				Hormone replacement therapy?	Yes	No
Trichomoniasis				History of sexually transmitted infections?	Yes	No
Bacterial Vaginosis (BV)				Use of birth control pills		
Yeast Infection				If yes, how long?		
Sexually Active						
Use safer sex practices						