**Dorothy Fairley, ND**
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Phone: 604.738.2205

Date_____

Name_____
Address_____
City_____Province_____Postal Code_____
Telephone(home)_____(work)_____(cell)_____
Birthdate_____ Age_____ Sex: F M
Care Card number_____
How did you hear about the clinic?_____
Live alone___ with spouse/partner___ parents___ children___ friends___
Occupation_____Hrs/wk_____Retired_____
Other healthcare providers: MD_____
Naturopath_____Chiropractor_____
Others_____
Person to contact in an emergency_____
Relation to you_____ Phone_____

**What are your most important health concerns? List in order of importance:**

1. _____
2. _____
3. _____
4. _____

**Medical History (date where possible)**

General Health_____ Childhood illnesses: Mumps_____ Chicken pox_____
Measles_____ German Measles_____ Rheumatic Fever_____ Mononucleosis_____
Accidents, falls, injuries_____
Surgeries_____
X-rays, CAT Scans, MRIs, EEGs, EKGs_____

Asthma/Hayfever/Hives__Anemia__High Blood Pressure__Heart Disease__Diabetes__
Stroke__Thyroid Disease__Liver Disease__Kidney Disease__Cancer__Epilepsy__
Tuberculosis__Depression__Anxiety__Bipolar__Schizophrenia__Venereal Disease__

**Immunizations**

| | | | | | |
|---|---|---|---|---|---|
| Polio | Y | N | Pertussis | Y | N |
| Diphtheria | Y | N | Measles/Mumps/Rubella | Y | N |
| Tetanus | Y | N | Other_____ | | |

**Family History** – please indicate if Father(F), Mother (M), Sister(S), Brother(B),Child(C)
Asthma/Hayfever/Hives__Anemia__High Blood Pressure__Heart Disease__Diabetes__
Stroke__Thyroid Disease__Liver Disease__Kidney Disease__Cancer(type)_____
Epilepsy__TB__Depression__Anxiety__Bipolar__Schizophrenia__Venereal Disease__

**Current Medications** (circle any medications that you take)
Pain Relievers (Aspirin, Tylenol) Cortisone Anti-depressants Thyroid meds
Heart/Cholesterol/Diuretics Laxatives Sleeping Pills

Antacids (Rolaids, Tums) Antibiotics Anti-Anxiety
Other (including over the counter)_____

**Vitamins/Supplements**_____
_____

**Exercise/Frequency** **Hobbies**
_____ _____
_____ _____
_____ _____

**Diet** (Please list what you typically eat in a day)
Breakfast_____
Lunch_____
Dinner_____
Snacks_____
Drinks_____

**Current Medical History**
Height_____ Weight_____ Is this a change Y N
Allergies (food, drugs, allergens)_____

**Review of Systems**
**Skin/Hair**
Rashes__ Eczema/hives__ Acne/boils__
Itching__ Colour changes__ Lumps__
Recent moles__ Hair loss__ Dandruff__

**Head**
Head injuries__ Jaw/TMJ problems__ Headaches__

**Eyes**
Double vision__ Eye strain/pain__ Glaucoma__
Spots/Blurring__ Night Blindness__ Glasses__
Tearing/Dryness__ Colour Blindness__ Cataracts__

**Ears**
Impaired hearing__ Ringing__ Earaches__
Dizziness/fainting__

**Nose/Sinuses**
Frequent colds__ Congestion__ Nosebleeds__
Sinus problems__ Loss of smell__
Sinusitis__

**Mouth/Throat**
Sore throat Hoarseness__ Sore tongue__
Teeth grinding__ Gum problems__ Cavities__

**Neck**
Lumps__ Swollen glands__ Goiter__
Pain/stiff neck__

**Respiratory**

Cough__ Phlegm(colour)__ Bronchitis__
Coughing up blood__ Asthma__ Wheezing__
Shortness of breath__at night__ Pain on breathing__
Pneumonia__
Emphysema__ Pleurisy__

**Cardiovascular/Circulation**

High/Low blood pressure__ Irregular heartbeat__ Murmurs__
Chest pain__ Angina__ Blood clots__
Swelling in ankles__ Varicose veins__ Phlebitis__
Cold hands/feet__ Deep leg pain__

**Gastrointestinal**

Indigestion__ Bloating/gas__ Heartburn__
Ulcer__ Constipation__ Diarrhea__
Chronic laxative use__ Nausea__ Vomiting__
Abdominal pain/cramps__ Trouble swallowing__ Bad breath__
Jaundice (yellow skin) Gall bladder disease__
Bowel movements: How often?_____ Is this a change? Y N

**Urinary**

Pain on urination__ Frequency__at night__ Urgency__
Decreased flow__ Inability to hold urine__ Blood__
Change in colour__ Kidney stones__

**Female reproductive**

Age menses began____ Menses length_____ Cycle length____
PMS_____ What symptoms?_____
Menstrual cramps__ Heavy menses__ Light menses__
Irregular cycles__ Bleeding between periods__
Sexually active__ Birth control/protection (what?)_____
Sexual difficulties__ Painful intercourse__ Infertility__
Number of pregnancies__ Live births__ Miscarriages__ Abortions__
Vaginal discharge__ Vaginal sores__
Menopausal symptoms__ What symptoms?_____
Breast tenderness__ Nipple discharge__ Breast lumps__

**Male Reproductive**

Testicular pain__ Testicular masses__ Hernias__
Sexually active__ Birth control/Protection (what?)_____
Sexual difficulties__ Prostate disease__ Discharge/sores__

**Musculoskeletal**

Joint pain or stiffness__ Where?_____
Arthritis__ Where?_____
Weakness__ Where?_____
Muscle cramps/spasms__ Broken bones__ Sciatica__

**Neurologic**

Fainting__ Seizures__ Paralysis__
Numbness/tingling__ Memory loss__

**Endocrine**

Change in thirst__ Change in appetite__ Hypothyroid__

**General**

| | | | | | |
|---|---|---|---|---|---|
| Sleep well | Y | N | Awake rested | Y | N |
| Hours sleep/night | _____ | | | | |
| Enjoy your work | Y | N | Take time off | Y | N |
| Travel in past 10 years | Y | N | Where?_____ | | |
| Spend time outside | Y | N | Eat three meals/day | Y | N |
| Drink coffee/tea/cola | Y | N | Smoke cigarettes | Y | N |
| Drink alcohol | Y | N | Ever treated for drug dependence | Y | N |

Watch television for _____hours/day Read for _____hours/day

Level of stress in life recently high medium low

Any history of toxic exposure (what?)_____

How does your condition affect you?_____

Do you have any insight into why it is happening, and if so what?_____

_____

What do you enjoy most in your life?_____

Anything else you would like to add?_____