

Medical History Instruction

We have provided for your interest and convenience, a copy of our Medical History Form. Feel free to print the form and fill it out prior to arriving for your appointment. It is not required and there will be plenty of time at the time of your appointment to fill out the form.

Healthtrek Research Inc.

DR. S. Craig Wagstaff, N.D.
Naturopathic Physician

Health History Questionnaire

Name: _____ Date of Birth: _____

Occupation: _____ Telephone: _____

Address: _____

What are your major concerns?

1. _____

2. _____

3. _____

Current Weight: _____ Weight 1 Year Ago _____ Maximum Weight _____ When? _____

List Surgeries: 1. _____

2. _____

3. _____

Injuries: Broken Bones _____

Illnesses: Have you ever had

Measles

Chicken Pox

Diphtheria

Influenza

Any Bone Disease

Polio

Poor Sleep

Gonorrhoea

Jaundice

Tuberculosis

Cancer

German Measles

Stroke

Smallpox

Pleurisy

Bursitis

Meningitis

Syphilis

Epilepsy

Concussion

M.S.

Diabetes

Mumps

Scarlet Fever

Rheumatic Fever

Sciatica

Arthritis

Herpes

Anaemia

Migraine

Crohn's Disease

Diverticulitis

Food, Chemical or Drug Poisoning

Any Other Diseases, Please List: _____

Health History Questionnaire

Please check if the following symptoms are a current or recurring problem.

General

- | | | |
|--|---|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Change In Appetite | <input type="checkbox"/> Sudden Energy Drop (Time?) |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Craving | <input type="checkbox"/> Bleed or Bruise Easily |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Peculiar Tastes or Smells |

Skin and Hair

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Change in Hair or Skin Texture | <input type="checkbox"/> Recent Moles |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Other Hair or Skin Problems? |
| <input type="checkbox"/> Pimples | | |

Head, Eyes, Ears, Nose and Throat

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Colour Blindness | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Jaw Clicks or Pain |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Tooth Pain |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Mercury Tooth Fillings |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Ringing In Ears | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Using Glasses | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Sore On Lips or Tongue |
| <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> Enlarged Thyroid | |

Heart and Circulation

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hands or Feet |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Swelling Of Hands |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Swelling Of Feet |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blood Clots | |

Lungs and Breathing

- | | | |
|---|---|---|
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing Blood |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain with a Deep Breath | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Production of Phlegm (colour?) | <input type="checkbox"/> Other Problems |

Digestion and Elimination

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Abdominal Pain or Cramps | <input type="checkbox"/> Rectal Pain |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Nausea | <input type="checkbox"/> Haemorrhoids |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in Stool |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Long Term Laxative Use | <input type="checkbox"/> Diarrhoea |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Liver or Gall Bladder Disease | |

Health History Questionnaire

Genito-Urinary

- | | | |
|--|--|--|
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Unable To Hold Urine | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Urgency To Urinate | <input type="checkbox"/> Decrease In Flow | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Pain On Urination | <input type="checkbox"/> Distinctive or Odd Colour | <input type="checkbox"/> Sores On Genitals |
| <input type="checkbox"/> Do You Wake To Urinate? | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Low Libido |
| <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Other Problems | <input type="checkbox"/> Sex life satisfactory |

Women

- | | | |
|------------------------------------|---|--|
| _____ Age of First Menses | <input type="checkbox"/> Unusual Menses | <input type="checkbox"/> Irregular Periods |
| _____ Duration of Menses | <input type="checkbox"/> Heavy | <input type="checkbox"/> Painful Periods |
| _____ Days Between Menses | <input type="checkbox"/> Light | <input type="checkbox"/> Vaginal Discharge |
| _____ Date of Start of Last Menses | <input type="checkbox"/> Clots | <input type="checkbox"/> Vaginal Sores |
| _____ Date of Last PAP Exam | | <input type="checkbox"/> Breast Lumps |

Changes in body or emotions prior to menstruation?

Do you practise birth control? What type and for how long? _____

Number of Pregnancies _____ Number of Births _____ Miscarriages _____ Abortions _____

Muscles, Joints and Bones

- | | | |
|--|---|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Foot/Ankle Pain | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Hand/Wrist Pain | <input type="checkbox"/> Hip Pain | |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Other Joint or Bone Problem? | |

Brain, Nerves and Emotions

- | | | |
|---|--|--|
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Depression | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Quick Temper/Irritable | <input type="checkbox"/> Susceptible To Stress | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Areas of Numbness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Loss of Consciousness | | |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

Comments

Please describe any other problems you would like to discuss.

Health History Questionnaire

Family Medical History

Please indicate family member, and if on father's (F) or mother's (M) side of the family.

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental Health Issues |

Occupational Stress (chemical, physical, psychological)

- How many packs of cigarettes do you smoke a day?
 How much coffee, tea, cola or alcohol do you drink per week?

Describe Your Weekly Exercise

Current Medicines

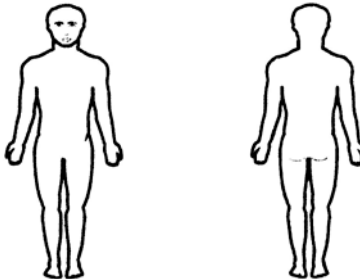
List all prescriptions, over the counter drugs, vitamins, herbs and any non-medicinal drugs.

Diet

Are you or have you ever been on a restricted diet? If so, what kind?

Please describe your average daily diet:

- Morning Afternoon Evening



Indicate Painful or Distressed Areas

Phone: 250-766-3633 Fax: 250-766-3627 Hours Monday – Thursday 9:00 a.m. to 5:00 p.m.

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