WEST COAST CLINIC OF OSTEOPATHY

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Health History Questionnaire
All information contained in this questionnaire is strictly confidential and will become part of your file.
No information is shared with third parties except at your request. Please print clearly.

Name First	Last	
Address Street		
City	Prov	Post Code
Telephone Home	Work/Cell	
DOB (dd/mm/yy) ☐ F ☐ M	**Email**	
Occupation	**Children** (Ages)	

Referred by
Physician's Details (Name)
(Address)

What is the main reason for your visit today?

Personal Health History

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Other (Please specify)		
Please check any conditions you had in the past or are suffering currently		
☐ Cancer	☐ Seizures	☐ Celiac disease
☐ Diabetes	☐ Multiple Sclerosis	☐ Mental illness
☐ Heart disease	☐ Asthma	☐ Arthritis
☐ Stroke	☐ Allergies	☐ Autoimmune disease
☐ High blood pressure	☐ Anemia	☐ Osteoporosis
Other (please specify)		

Surgeries	
Year	**Reason**

Other Hospitalizations	
Year	**Reason**

Please list any prescribed medications or over-the-counter drugs, vitamins or herbs you are currently taking

Please list any medications you have taken long term in the past

Allergies to medications (Name of medication and the reaction you had)	
Do you wear a medic alert bracelet? ☐ Yes ☐ No	**Reason**
List other allergies (eg dust mite, food allergies)	

Health Habits			
Exercise, hobbies (Type, frequency)			
Diet	☐ Vegetarian ☐ Vegan	Are you on a particular diet at present? (Type)	
Water	How many glasses of water do you drink in a day?		
Caffeine	☐ Coffee ☐ Tea ☐ Cola	Cups/cans per week?	
Alcohol	Do you drink alcohol? ☐ Yes ☐ No	Drinks per week? Type	
Tobacco	Do you smoke or have you smoked in the past? ☐ Yes ☐ No	Cigarettes per day?	
Drugs	Do you or have you in the past used recreational or street drugs? ☐ Yes ☐ No		
If yes please name type			
Do you have difficulty sleeping? ☐ Y ☐ N	**Hours sleep per night**		

Family Medical History Please check off any conditions a family member has suffered. Please indicate whose side it was on (M=Mother, F=Father)		
☐ Cancer ☐ M ☐ F	☐ Seizures ☐ M ☐ F	☐ Celiac disease ☐ M ☐ F
☐ Diabetes ☐ M ☐ F	☐ Multiple Sclerosis ☐ M ☐ F	☐ Mental illness ☐ M ☐ F
☐ Heart disease ☐ M ☐ F	☐ Asthma ☐ M ☐ F	☐ Arthritis ☐ M ☐ F
☐ Stroke ☐ M ☐ F	☐ Allergies ☐ M ☐ F	☐ Autoimmune disease ☐ M ☐ F
☐ High blood pressure ☐ M ☐ F	☐ Anemia ☐ M ☐ F	☐ Osteoporosis ☐ M ☐ F
Other (please specify)		

Please check off any conditions you are suffering from or have suffered in the past.

General		
☐ Poor appetite	☐ Strong thirst	☐ Weight gain
☐ Change in appetite	☐ Night sweats	☐ Weight loss
☐ Poor sleep	☐ Recurring infections	☐ Chills
☐ Fatigue	☐ Bleed/bruise easily	☐ Fevers
☐ Cravings	☐ Peculiar tastes or smells	☐ Blackouts

Skin		
☐ Rashes	☐ Dry hair/skin	☐ Recent moles/changes
☐ Itching	☐ Hair loss	☐ Ulcerations
☐ Eczema	☐ Dandruff	☐ Other hair/skin problems

Ears, Eyes, Nose and Throat		
☐ Eye pain	☐ Cataracts	☐ Nose bleeds
☐ Eye strain	☐ Earache	☐ Recurrent sore throats
☐ Wear glasses	☐ Poor hearing	☐ Sores on lips/tongue
☐ Blurry vision	☐ Ringing in ears	☐ Polyps in nose
☐ Night blindness	☐ Facial pain	☐ History of nose injury or fracture
☐ Colour blindness	☐ Sinus problems	☐ Other

Dental		
☐ Face pain	☐ Have you worn braces?	☐ Wisdom teeth removed
☐ Teeth removed	☐ Jaw painful or clicks	☐ Other major dental work
☐ Toothache	☐ Do you wear dentures or a bridge?	☐ Trauma to teeth (blows,falls)
☐ Mercury (silver) fillings	☐ Root canals?	

Heart and Circulation		
☐ High blood pressure	☐ Varicose veins	☐ Shortness of breath
☐ Low blood pressure	☐ Blood clots	☐ High cholesterol
☐ Irregular heart beat	☐ Deep vein thrombosis	☐ Leg pain with walking that is eased by stopping or resting
☐ Dizziness	☐ Cold hands/feet	
☐ Fainting	☐ Swelling of hands	☐ Other
☐ Chest pain	☐ Swelling of feet	

Digestion and Elimination		
☐ Indigestion/burning/reflux	☐ Abdominal cramps	☐ Pain passing bowel motion
☐ Gas	☐ Nausea	☐ Blood in stools
☐ Bad breath	☐ Vomiting	☐ Fatty stools
☐ Constipation	☐ Chronic laxative use	☐ Gallstones
☐ Diarrhea	☐ Rectal pain	☐ Gallbladder/liver problems
☐ Bloating	☐Hemorrhoids	☐ Other

Lungs and Breathing		
☐ Breathlessness	☐ Coughing blood	☐ Pain with a deep breath
☐ Wheezing	☐ Bronchitis	☐ Collapsed lung
☐ Cough	☐ Pneumonia	☐ Other
☐ Phlegm (colour?)	☐ Asthma	

Genito-Urinary		
☐ Frequent urination	☐ Unable to hold urine	☐ Bladder/kidney infections
☐ Urgency to urinate	☐ Strong smelling urine	☐ Impotency
☐ Pain on urination	☐ Distinctive odour or colour	☐ Other
☐ Do you wake at night to urinate?	☐ Blood in urine	
☐ Problem maintaining flow	☐ Bladder/kidney stones	

Men only		
☐ Prostate problems	☐ Painful intercourse	Have you ever had a prostate exam? ☐ Y ☐ N
☐ Erectile dysfunction	☐ Penile/testicular lumps/bumps	
☐ Penile discharge	☐ Other	If yes, was it normal? ☐ Y ☐ N

Women only		
☐ Endometriosis	☐ Painful breasts	What was the date of your last pap smear? Was it normal? ☐ Y ☐N
☐ Fibroids	☐ Breast lumps	
☐ Ovarian cysts	☐ Vaginal discharge	What was the date of your last breast exam? Was it normal? ☐ Y ☐N
☐ Painful or irregular periods	☐ Uterine/bladder prolapse	
☐ Premenstrual tension	☐ Intrauterine device/coil	Number of pregnancies
☐ Going through menopause	☐ Contraception/type?	Number of births
☐ Post menopausal	☐ History of pelvic inflammatory disease	Miscarriages
☐ Painful intercourse		Abortions
Are you pregnant, or is there a possibility that you are pregnant at present? ☐ Y ☐N		

Nervous System		
☐ Panic attacks	☐ Depression	☐ Twitching muscles/limbs
☐ Loss of balance	☐ Susceptible to stress	☐ Tremor
☐ Poor coordination	☐ Areas of numbness	☐ Slurring speech
☐ Dizziness	☐ Weak muscles	☐ Concussion/blows to head or face
☐ Quick temper/irritable	☐ Tic	☐ Other

How would you rate your stress levels at present?									
No stress									**Extreme stress**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Comments
Is there anything else you would like to add?