

NEW PATIENT QUESTIONNAIRE

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Date: _____

Last name: _____ First Name: _____

Address: _____ City: _____

Postal Code: _____ Email: _____

Home Phone: _____ Other: _____

Date of Birth: ____/____/____ (mm/dd/yy)

Gender: ___F ___M

Marital Status: _____ Children if Any: _____

Referred by: _____

Occupation: _____

Do you have extended health insurance? ___Yes ___No

Your Doctor's name: _____ Doctor's Phone #: _____

Person to contact in case of emergency:

Last name: _____ First Name: _____

Relation: _____ Phone #: _____

Comprehensive Profile:

Major Complaint(s) and in order of importance for you?

Complaint:	Since:	Causes:
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications are you currently taking?

Medication(s):	Since:	Adverse effects:
_____	_____	_____
_____	_____	_____
_____	_____	_____

What other treatment/regimens are you currently following?

Treatment(s):

Since:

Results:

What hospitalizations or surgeries have you had?

Surgery/ Hospital:

When:

Complications:

Which of the following conditions have you had?

Abscesses

Alcoholism

Allergies

Amnesia

Angina

Arthritis

Asthma

Bronchitis

Chicken Pox

Cold Sores

Colitis

Depression

Diabetes

Diphtheria

Emphysema

Epilepsy

Frequent Colds

Gall stones

Goitre

Gonorrhoea

Gout

Hayfever

Heart Disease

Hepatitis

Herpes Genitalia

Hernia

Hypoglycemia

High blood pressure

Influenza

Kidney Stones

Leukemia

Malaria

Measles

Meningitis

Miscarriage

Mononucleosis

Mumps

Neuritis

Painful/Achy Joints

Pancreatitis

Pelvic Infl. Disease

Peritonitis

Prostatitis

Rheumatic Fever

Rubella

Scarlet Fever

Sciatica

Sexual Abuse

Skin disease

Strep Throat

Sinusitis

Small Pox

Sunstroke

Stroke

Syphilis

Tonsillitis

Tuberculosis

Typhoid Fever

Thyroid Problems

Venereal Warts

Whooping Cough

Worms

Yellow Fever

Any other major conditions/ Surgery? _____

Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Yes No

Which ones? _____

What major injuries have you had?

Injury:

When:

Long term effects:

How much of the following substances are you using? (D=daily, W=weekly, M=monthly, O=occasionally)

Tobacco: _____D/W/M/O

Alcohol: _____D/W/M/O

Coffee: _____ D/W/M/O

Recreational drugs: _____ D/W/M/O

Age of first menses: _____

What vaccinations have you had?

Check off any immunizations you have received:

Polio DPT MMR Tetanus
 Small Pox Chicken Pox Hepatitis

Any adverse side effects from the above? Yes No

Allergies:

What exercise do you do and how often?

Indicate below, which of the following ailments, or any other major ailments have affected your relatives:

Alcoholism Gout
 Allergies Hay Fever
 Arthritis Heart Disease
 Asthma Insanity
 cancer Paralysis
 Depression Pneumonia
 Diabetes Skin disease
 Epilepsy Syphilis
 Gonorrhoea Tuberculosis

Relative:	Age if Alive:	Age at death:	Ailments:
Mother	_____	_____	_____
Father	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Children	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Maternal Aunts/Uncles	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Aunts/Uncles	_____	_____	_____

Are you currently under the care of another physician? Yes No

Physician:	For what Condition (s)?	Treatment:
_____	_____	_____
_____	_____	_____
_____	_____	_____

If not, then why? _____

What Medications do you regularly take?

<input type="checkbox"/> Digestive Enzymes	<input type="checkbox"/> Antacids	<input type="checkbox"/> Blood Pressure Pills
<input type="checkbox"/> Sedatives	<input type="checkbox"/> Sleeping Pills	<input type="checkbox"/> Thyroid Medicine
<input type="checkbox"/> Painkillers	<input type="checkbox"/> Megavitamins	<input type="checkbox"/> Cortisone
<input type="checkbox"/> Laxatives	<input type="checkbox"/> Hormone Replacement	<input type="checkbox"/> Herbs
<input type="checkbox"/> Birth Control Pills	Other: _____	

What habits/lifestyle do you have?:

<input type="checkbox"/> Awaken refreshed	<input type="checkbox"/> Have trouble relaxing
<input type="checkbox"/> Have trouble sleeping	<input type="checkbox"/> Have problems at work or home
<input type="checkbox"/> Feels stressed often	<input type="checkbox"/> Get constipated often

Review of Systems

Y= A condition you have now **N=** A condition you've **NEVER** had **P=** A condition you've had in the past

(Please indicate with the appropriate letter on the lines below)

General:	Y N P	Head:	Y N P
Fatigue/Weakness	_____	Headache	_____
Fever/chills	_____	Head Injury	_____
Skin:	Y N P	Dizziness	_____
Rashes	_____	Vertigo	_____
Eczema	_____	Migraines	_____
Acne	_____	Pulsations	_____
Boiling	_____	Eyes:	Y N P
Itching	_____	Impaired Vision	_____
Color change	_____	Glasses/Contacts	_____
Lumps	_____	Eye Pain	_____
Night sweats	_____	Tearing	_____
Dryness	_____	Dryness	_____
Moistness	_____	Double Vision	_____
Temperature	_____	Glaucoma	_____
Nail changes	_____	Cataracts	_____
Changes in mole(s)	_____	Blurring	_____
Skin Cancer	_____	Bothered by sun/light	_____
Hives	_____	Itching	_____
Excess perspiration	_____	Redness	_____
Scaling	_____	Discharge	_____
Difficulty growing nails	_____	Blind Spot	_____
Warts	_____	Near/far sighted	_____
Dry Hair	_____		
Falling/ thinning hair	_____		

Ears: Y N P

Impaired hearing _____
Earache _____
Dizziness _____
Discharge _____
Infections _____
Ringing _____
Buzzing _____
Redness _____

Nose and Sinuses: Y N P

Frequent colds _____
Nose bleeds _____
Stiffness _____
Hay Fever _____
Sinus Problems _____
Discharge _____
Obstruction _____
Loss of Smell _____

Mouth and Throat: Y N P

Frequent sore throat _____
Sore tongue/ mouth _____
Gum problems _____
Hoarseness _____
Dental Cavities _____
Loss of taste _____
Dry/chapped lips _____
Cankers _____

Neck: Y N P

Lumps _____
Swollen glands/lymph _____
Goiter _____
Pain or stiffness _____
Difficulty swallowing _____

Respiratory: Y N P

Cough _____
Sputum/mucous _____
Spitting up blood _____
Wheezing _____
Asthma _____
Bronchitis _____
Pneumonia _____
Pleurisy _____
Emphysema _____
Difficulty breathing _____
Pain on breathing _____
Shortness of breath _____
Shortness of breath at night _____

Cardiovascular: Y N P

Heart disease _____
Angina _____
High blood pressure _____
Murmurs _____
Rheumatic Fever _____
Chest pain _____
Swelling in ankles _____
Palpitations _____
Hear your heart beating _____
Cyanosis _____
ECG _____
Heart testing _____
Pain in chest on exertion _____
Blue lips _____

Peripheral: Y N P

Deep leg pain _____
Cold hands/feet _____
Varicose veins _____
Thrombophlebitis _____
Leg Cramps _____
Numbness _____
Coldness _____
Swelling _____
Ulcers _____

Gastrointestinal: Y N P

Trouble swallowing _____
Heartburn _____
Change in Thirst _____
Change in appetite _____
Nausea _____
Vomiting _____
Vomiting blood _____
Regular bowel movements _____
Changes in B.M _____
Blood in stool _____
Belching or gas _____
Jaundice _____
Liver disease _____
Gall bladder disease _____
Ulcer _____
Indigestion _____
Diarrhea _____
Rectal bleeding _____
Hemorrhoids _____
Black, tarry stool _____
Abdominal pain _____
Food Allergy _____
Hernias _____
Hunger after eating _____

Tuberculosis _____
Tuberculin test _____
Chest X-ray _____

Urinary: Y N P

Pain on urination _____
Increased frequency _____
Frequency at night _____
Inability to hold urine _____
Frequent infections _____
Kidney stones _____
Blood in urine _____
Urgency _____
Hesitancy _____

Male Concerns: Y N P

Hernias _____
Testicular masses _____
Testicular pain _____
Sexually active? _____
Sexual difficulties _____
Venereal disease _____
Discharge or sores _____

Female Concerns: Y N P

Age of first Menses _____
Average # of days _____
Length of cycle _____
Bleeding between period _____
Regularity of cycle _____
Painful menses _____
Excessive flow _____
Scanty flow _____
PMS _____
Birth-control _____
of pregnancies _____
of live births _____
of miscarriages _____
of abortions _____
Difficulty Conceiving _____
Sexually Active? _____
Venereal Disease _____
Last menstrual period _____
Vaginal Discharge _____
Vaginal itching _____
Last PAP _____
Ceasing of menses _____
Hot flashes _____

Breasts: Y N P

Do you self-exam? _____
Lumps _____

Musculoskeletal: Y N P

Joint pain or stiffness _____
Backache _____
Broken bones _____
Muscle spasms _____
Weakness _____
Joint swelling _____
Tight muscles _____
Muscle twitching _____

Neurological: Y N P

Fainting _____
Seizures/convulsions _____
Paralysis _____
Muscle weakness _____
Numbness or tingling _____
Loss of memory _____
Involuntary movement _____
Loss of balance _____
Speech problems _____
Tremors _____
Difficulty concentrating _____
Difficulty initiating movement _____

Endocrine: Y N P

Heat or cold intolerance _____
Thyroid Disease _____
Excessive thirst _____
Excessive hunger _____
Excessive urination _____
Excessive sweating _____
Diabetes _____
Hypoglycemia _____
Hormone therapy _____
Sudden weight loss/gain _____

Blood / Lymphatic: Y N P

Anemia _____
Easy bleeding or bruising _____
Part Transfusions _____
Lymph node swelling _____

Allergic History: Y N P

Drug sensitivity _____
Reaction to vaccine _____
Allergies _____

Injuries: Y N P

Broken bones _____
Sprains _____

Pain/Tenderness _____
Nipple Discharges _____

Whiplash _____
Lacerations _____

Mental / Emotional: Y N P

Sleep / Dreams: Y N P

Anger _____
Bitterness _____
Un-forgiveness _____
Depression _____
Mood swings _____
Anxiety _____
Nervousness _____
Tension _____
Fears/Phobia _____

Do you wake rested? _____
Do you sleep enough? _____
Early Riser _____
Do you recall dreaming? _____
Do you have thematic or reoccurring dreams?

Alcohol/drug abuse _____
Insomnia _____
Irritability _____
Decreased sexual drive _____
Problems with memory _____
Problems with concentration _____

Other: Y N P

Consume 3 meals a day _____
Enjoy employment _____
Watch Television _____
Read books _____
Take vacations _____
Treatment for drug dependence _____
Use of recreational drugs _____
Use of alcohol _____
Treatment for alcoholism _____

What are your main interests/ hobbies?

Do you exercise? How/how often?

Anything else?
