

NEW PATIENT QUESTIONNAIRE

DR. SHARON EDWARDS HD(RHOM), DNM, RNCP
45 Dalkeith Drive, Unit #11 Brantford, ON N3P 1M1

Email: info@dvineliving.com Tel: (519) 750-0440 Fax: (519) 750-0497 Web: www.dvineliving.com

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?

- | | | |
|---|---|---|
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Amnesia | <input type="checkbox"/> Herpes Genitalia | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Influenza | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Sunstroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Gall stones | <input type="checkbox"/> Painful/Achy Joints | <input type="checkbox"/> Venereal Warts |
| <input type="checkbox"/> Goitre | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Pelvic Infl. Disease | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Peritonitis | <input type="checkbox"/> 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

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?

