UNIVERSAL MEDICAL CENTRE

2153 Armstrong Street Sudbury ON P3E 4W2
Email: universalmedicalcentresudbury@gmail.com
Phone: (705)-523-9100 Fax: (705)-523-9140

Patient InTake Form

To help us serve your health needs, please complete the following information as accurately as possible. Thank you!

Date (DD/MM/YY) _____ Name _____

Age _____ Birth Date _____ Gender _____

Home Address _____ City _____ Postal Code _____

Work Phone Number _____ Home Phone Number _____

Best Time to Call _____ Occupation _____

Marital Status _____ Name of Spouse _____ Dependants _____

Emergency Contact Name _____ Relation _____ Phone Number _____

How did you hear about the Universal Medical Centre?

_____

Please list below all other health professionals you are currently seeing (complimentary and conventional) and their contact phone numbers

1. _____ 2. _____ 3. _____

_____ _____ _____

( ) - ( ) - ( ) -

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us in writing to do so. Please complete this questionnaire as thoroughly as possible. Thank you.

CURRENT HEALTH CONCERNS

What health concerns/problems brought you to this office today?
If you have a specific health condition please describe it in detail.

How long has this been troubling you?

Please list treatments you have had for this condition
(surgery, acupuncture, massage, etc.) results, and dates

Who diagnosed your illness?

When was this diagnosis made?

What specialists have you seen? (Indicate the year of consultation)

In order of importance, list any other health problems that are concerning you:

1. Since when?

2. Since when?

3. Since when?

4. Since when?

Other concerns

CURRENT MEDICATIONS

Please list all prescription and non-prescription medications you are currently taking (such as sleeping pills, birth control pills, aspirin, laxatives, etc.)

Please list all vitamins, herbs, homeopathics, etc., that you are currently taking:

List all prescribed medications you've taken in the past for any period longer than three months:

List any prescribed medication you have had an adverse reaction to in the past. Indicate the drug name, when you took it, and the reaction had:

Hospitalizations, Surgeries, or Serious injuries (Date/Reason for hospitalization):

Describe your general state of health as a child:

HEALTH HISTORY

Your general state of health is (circle one): excellent good average fair poor

Height _____ Current Weight _____ Weight 1 Year Ago _____

Maximum Weight _____ Year _____ Minimum Weight _____ Year _____

Please list any allergies to any drugs, herbs, foods, animals, chemicals or other:

_____

Smoker? (circle one) yes / no Years Smoking _____

Amount per day _____ Year Stopped (optional) _____

Have you been vaccinated? childhood vaccines, other, etc (If so when)

_____

Do you currently use any of the following? (indicate how often, how much and for how long)

Alcohol? (circle one) yes / no how often, how much and for how long? _____

Soft Drinks? (circle one) yes / no how often, how much and for how long? _____

Coffee? (circle one) yes / no how often, how much and for how long? _____

Marijuana? (circle one) yes / no how often, how much and for how long? _____

Black Tea? (circle one) yes / no how often, how much and for how long? _____

Other Recreational Drugs? yes / no how often, how much and for how long? _____

Are there any food groups that you avoid? If 'yes', please list, and explain why:

_____

MEDICAL HISTORY

Please check only those that pertain to YOU personally (number earliest to latest):

_ Alcohol Abuse
_ Allergies
_ Anemia
_ Asthma
_ Arthritis
_ Back, Muscle, Joint Pain
_ Bladder/Urinary Problems
_ Bowel Disease
_ Cancer
_ Candida
_ Chronic infections
_ Constipation
_ Depression
_ Diabetes
_ Eczema
_ Epilepsy
_ Fatigue, chronic
_ Tuberculosis

_ Female Gynecological Problems
_ Gallstones
_ Gout
_ Gum/Teeth Problems
_ Hay Fever
_ Heart Attack
_ Heart Problems
_ High Blood Pressure
_ Hives
_ Hypoglycemia
_ Canker sores
_ Ear Infections
_ Influenza
_ Hepatitis
_ Kidney problems
_ Liver problems
_ Lung problems
_ Ulcers

_ Malaria
_ Measles
_ Mononucleosis
_ Obesity
_ Pleurisy
_ Pneumonia
_ Psychological difficulty
_ Rheumatic Fever
_ Rheumatism
_ Oral Herpes
_ Skin Problems
_ Sinusitis, chronic
_ Stroke
_ Suicidal
_ Swollen glands, chronic
_ Thyroid problems
_ Tonsilitis
_ Venereal Disease
(i.e. AIDS, syphillis, Gonorrhea)

MENTAL EMOTIONAL HEALTH

Have you had any of the following conditions (check if applicable):

_ Chronic Anxiety
_ Minor Depression
_ Obsessive-Compulsive Disorder
_ Post Traumatic Stress Disorder

_ Manic Depression
_ Panic Attacks
_ Schizophrenia

_ Major Depressio
_ Dysthymic Disorder
_ Other

FEMALE REPRODUCTION

Age of first period _____

Age at menopause _____

Length of cycles _____

Length of bleeds _____

Are they (circle all that apply):

heavy medium light clotted dark light colour

Do you have spotting or bleeding between periods, if yes since when?

_____

Do you have PMS? (circle all that apply)

bloating breast tenderness irritability depression headaches mood swings food cravings weight gain

Number of pregnancies _____

Number of miscarriages _____

Number of live births _____

Difficulty conceiving? yes / no

Are you currently pregnant? yes / no

Please list below the dates and results of last:

PAP Smear _____

_____

Mammogram _____

_____

Self Breast Exam _____

_____

Have you ever been or are now physically or sexually abused? yes / no

Are you sexually active? yes / no

If you use birth control, what kind?

_____

MALE REPRODUCTION

Any problems with impotency? yes / no

Any known prostate problems? yes / no

If so describe:

Any sores on your penis? yes / no

Any problems urinating? yes / no

Any discharge? yes / no

Date of last prostate examination:

Date of last self testicular examination:

Are you sexually active? yes / no

If you use birth control, what kind?

Have you ever been or are now physically or sexually abused? yes / no

WORK AND HOME ENVIRONMENT

Is your home damp or moldy? yes / no

How is your home heated?

Describe the emotional environment at your home:

Describe the emotional environment at your work:

Please sketch or write down something in the space below that would reflect your present condition

LIFESTYLE

Are you (circle all that apply):

married separated divorced widowed single in a supportive relationship other

If other, please describe:

What do you enjoy most in your life?

What are your main interests and hobbies?

What do you worry most about your life?

What level of personal stress are you experiencing right now (circle all that apply):

Minimal Average Considerable Unbearable

Is the main stressor in your life (circle all that apply):

Financial Job Related Marriage Interpersonal Health Unfulfilled Expectations Family Members Spiritual

Do you exercise regularly? yes / no

Type of exercise

Duration

Frequency

Do you have dietary restrictions, religious or ethical?

Do you meditate or pray?

Do you enjoy your work? yes / no

Do you take vacations? yes / no

When was your last vacation?

How many hours of sleep do you get on average?

Do you wake rested?

How often do you get colds and flus?

FAMILY HISTORY

Indicate (with M/F) if there have been any of the following diseases in your Blood relatives:
(M=mother F=father)

_ Allergies	_ Depression	_ Mental illness
_ Alzheimer's disease	_ Diabetes	_ Rheumatism
_ Anemia	_ Eczema	_ Schizophrenia
_ Arthritis	_ Heart disease	_ Seizures
_ Asthma	_ Hypertension	_ Stroke
_ Bipolar disorder	_ Hypoglycemia	_ Thyroid disease
_ Cancer	_ Goiter	_ Tuberculosis
_ Cataracts	_ Kidney disease	other _____

	Age	Health Problems	If Deceased, Cause of Death	If Deceased, Age at Death
Father				
Mother				
Siblings				
Children				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				