



CLIENT PROFILE

Family Doctor:

Name _____

Address _____

Telephone Number _____

Fax Number _____

Client's OHIP Number _____

Client's Name _____ Email _____

Address _____

Phone Number _____ Work Number _____

Date of Birth Year _____ Month _____ Day _____ Age _____

Occupation: _____

PAST HISTORY/RISK FACTORS:

Have you had or do you have:

	Yes	No	
High Blood Pressure	()	()	
Diabetes	()	()	
Asthma	()	()	
Epilepsy	()	()	
Heart Murmur	()	()	
Heart Disease	()	()	
Ulcer Disease	()	()	
Blood Transfusion	()	()	
Abdominal Disease	()	()	()
Hepatitis	()	()	()
Kidney Disease	()	()	
Thyroid	()	()	
Migraine	()	()	()
Chest Pain	()	()	
Shortness of Breath	()	()	
Recent Cough/Cold	()	()	
Skin Disease	()	()	
Psychiatric Problems	()	()	

Please List Previous Operations, Injuries, & Ongoing Medical Problems

When _____

Pregnancy _____

ONGOING PSYCHOLOGICAL HEALTH CONDITIONS/SOCIAL HISTORY:

Smoking _____ Years _____

Alcohol Intake - Yes ___ No _____ Quantity _____

Other Substances or Addictions _____

LONG-TERM TREATMENT REGIMEN:

Have You Recently Taken These Medications:

	Yes	No	
Aspirin/Tylenol	()	()	
Blood Thinners	()	()	
Birth Control Pills	()	()	()
Blood Pressure Pills	()	()	()
Diabetes Medications	()	()	
Tranquilizers	()	()	
Steroids/Cortisone	()	()	()
Heart Pills	()	()	

Please List the Major Illnesses in Close Family Members, e.g. Diabetes, Heart Disease, High Blood Pressure, Cancer

Father _____

Mother _____

Brother/Sister _____

Grandparents _____

Children _____

WHAT MEDICATIONS ARE YOU NOW TAKING?

ANY ALLERGIES AND SENSITIVITIES?

What reaction did you have? _____
