



# PATIENT INFORMATION

Morgan Winton, BSc ND

Name \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Birthdate: \_\_\_\_\_

City \_\_\_\_\_ Age: \_\_\_\_\_

Province \_\_\_\_\_ Marital Status: \_\_\_\_\_

Postal Code \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone \_\_\_\_\_ Gender:  Male  Female

Cell Phone \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Work Phone \_\_\_\_\_ Phone Number: \_\_\_\_\_

May we leave messages?  Yes  No

E-mail Address \_\_\_\_\_

Check here if you do NOT want to receive any correspondence from the office

How did you hear about our clinic \_\_\_\_\_

## CURRENT HEALTH INFORMATION

Names of other health care providers \_\_\_\_\_

Please list your health concerns that you would like to address, in order of importance:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Please list any other health conditions that you have \_\_\_\_\_



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## MEDICATIONS

How many courses of antibiotics have you had in the past 2 years? \_\_\_\_\_

Are you allergic or sensitive to any medications or other substances?  No  Yes

If so, please list (include medications, foods, environmental allergens, chemicals, etc.):

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Please list all medications, prescriptions, herbs, vitamins, and homeopathics that you are presently taking:

Name of Medication	Dosage	Frequency	Date Started

## LIFESTYLE FACTORS

Do you drink alcohol? If so, how many drinks per week? \_\_\_\_\_

Do you smoke? If so, how many packs per week? \_\_\_\_\_

Are you exposed to second hand smoke? If so, how often? \_\_\_\_\_

Do you use recreational drugs? If so, how often? \_\_\_\_\_

Do you exercise? If so, how often? \_\_\_\_\_

Rate your stress level (please circle): Low      Average      High      Very High      Unbearable

What area of your life contributes most to your stress (please circle):

Work      Health      Family      Money      Marriage      Other: \_\_\_\_\_



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## PAST MEDICAL HISTORY

What hospitalizations or surgeries have you had and when did they occur?

### Immunizations (please check):

- |  |                                   |   |
|--|-----------------------------------|---|
| <input type="radio"/> Flu Shot                     | <input type="radio"/> Hepatitis B | <input type="radio"/> Measles/Mumps/Rubella |
| <input type="radio"/> Diphtheria/Pertussis/Tetanus | <input type="radio"/> Hepatitis A | <input type="radio"/> Chicken Pox           |
| <input type="radio"/> Polio                        |                                   |   |

### Childhood Illnesses (please check):

- |  |                                       |  |
|--|---------------------------------------|--|
| <input type="radio"/> Chicken Pox              | <input type="radio"/> Whooping Cough  | <input type="radio"/> Eczema                           |
| <input type="radio"/> Mumps                    | <input type="radio"/> Polio           | <input type="radio"/> Asthma                           |
| <input type="radio"/> Measles                  | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Diphtheria                       |
| <input type="radio"/> Rubella (German Measles) | <input type="radio"/> Scarlet Fever   | <input type="radio"/> Frequent ear infections or colds |
| <input type="radio"/> Other _____              |                                       |  |

## FAMILY HISTORY

Please indicate if any of your family members have had any of the following:

Condition	Relative	Condition	Relative
Alcoholism		Heart Disease	
Allergies		High blood pressure	
Alzheimer's		High cholesterol	
Arthritis		Infertility	
Asthma		Kidney disease	
Bleeding		Disorder Mental disease	
Cancer (indicate type)		Obesity	
Depression		Osteoporosis	
Diabetes		Thyroid Problem	
Drug Addiction		Stroke	

