



PERSONAL INFORMATION

Name _____ Date of First Visit _____

Address _____

City _____ Province _____ Postal Code _____

Telephone # (home) _____ (work) _____

E-mail Address _____ Relationship Status _____

Age _____ Date of Birth (M/D/Y) _____ Gender: female _____ male _____

Occupation _____ Hours per week _____ Employer _____

Has any other family member already been a patient at the clinic? _____

Next of Kin or other to reach in an emergency _____

Relationship _____ Phone _____

HEALTH OVERVIEW

Name of current general practitioner (MD) _____

GP's contact information _____

When was your last visit to your GP? _____

What was the reason? _____

Are you seeing a medical specialist? Y N

If yes, for what reason? _____

Name of medical specialist _____

Do you have any known contagious diseases at this time? Y N If yes, what? _____

What is the main reason for your visit today? _____

What are your most important health concerns? List as many as you can in order of importance.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

How did you hear about our clinic? _____

Consent and Cancellation Policy

I hereby consent to receive treatment by the practitioners of Sage Clinic. I understand that I am responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

Email Correspondence (we will not sell, rent, or share your email address)

Yes No - I would like to receive Sage Clinic's free monthly email newsletter, which contains information about clinic events and health conditions, current health news, and inspiring health quotations.

Yes No - Sage Clinic may correspond with me at the above email address.

Signature: _____ Today's date: _____

(Parent or Guardian if a minor)

HEALTH HISTORY QUESTIONNAIRE

FAMILY HISTORY

Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart Disease
Kidney Disease	Epilepsy	High Blood Pressure
Tuberculosis	Stroke	High Cholesterol
Asthma / Hayfever / Hives	Arthritis	Anemia

Any other relevant family history? _____

What is your ethnic heritage? _____

CHILDHOOD ILLNESSES

Scarlet Fever	Diphtheria	Rheumatic Fever
Mumps	Measles	German Measles

IMMUNIZATIONS

Polio	Pertussis
Tetanus shot: when? _____	Diphtheria
Measles / Mumps / Rubella	Travel Related:

HOSPITALIZATIONS, SURGERIES, IMAGING

What hospitalizations or surgeries, X-rays, CAT scans, EEG, EKG's have you had?

_____ year: _____ _____ year: _____
 _____ year: _____ _____ year: _____
 _____ year: _____ _____ year: _____
 _____ year: _____ _____ year: _____

ALLERGIES / SENSITIVITIES

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

CURRENT MEDICATIONS

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking?

- 1) _____ 5) _____
 2) _____ 6) _____
 3) _____ 7) _____
 4) _____ 8) _____

GENERAL

Height _____ Weight _____ lbs. Weight 1 year ago _____ lbs.
 Max Weight ____ lbs. When _____ Min Adult Weight _____ lbs When _____
 When during the day is your energy the best? _____ worst? _____

REVIEW OF SYSTEMS

Check (✓) any of the following conditions you currently have (C), or have had in the past (P). Please also check if you feel any of the following are a significant part of your medical history.

C P

LIFESTYLE

		Alcohol
		Marijuana
		Drugs
		Treated for drug dependence
		Stress

		History of Smoking
		- How many packs per day?
		- How many years?
		Occupational Hazards
		Any major traumas

MENTAL/ EMOTIONAL

		Treated for emotional problems
		Mood swings
		Considered/attempted suicide
		Poor Concentration

		Depression
		Anxiety or nervousness
		Tension
		Memory problems

ENDOCRINE

		Hypothyroid
		Hypoglycemia
		Excessive thirst
		Fatigue

		Heat or cold intolerance
		Diabetes
		Excessive hunger
		Seasonal depression

IMMUNE

		Chronic fatigue syndrome
		Chronically swollen glands
		Reactions to vaccines

		Chronic infections
		Slow wound healing
		Reactions to immunizations

NEUROLOGIC

		Seizures
		Muscle weakness
		Tremor
		Vertigo or dizziness

		Heat or cold intolerance
		Numbness/tingling of extremities
		Loss of memory
		Difficulty Concentrating

SKIN

		Rashes
		Acne/boils
		Color change
		Lumps

		Eczema, Hives
		Itching
		Perpetual hair loss
		Night sweats

HEAD

		Headaches
		Migraines

		Head injury
		Jaw/TMJ problems

EYES

		Spots in eyes
		Impaired vision
		Blurriness
		Color blindness
		Double vision

		Cataracts
		Glasses or contacts
		Eye strain/pain
		Tearing or dryness
		Glaucoma

EARS

		Impaired hearing
		Earaches

		Ringing in the ears/Tinnitus
		Dizziness

NOSE AND SINUSES

		Frequent colds
		Stuffiness or post-nasal drip
		Sinus problems

		Nose bleeds
		Hayfever
		Loss of smell

MOUTH AND THROAT

		Frequent sore throat
		Teeth grinding
		Gum problems
		Dental cavities

		Copious saliva
		Sore tongue/lips
		Hoarseness
		Jaw clicks

NECK

		Lumps
		Goiter

		Swollen glands
		Pain or stiffness

RESPIRATORY

		Cough
		Spitting up blood
		Asthma
		Pneumonia
		Emphysema
		Pain on breathing
		Shortness of breath at night

		Sputum
		Wheezing
		Bronchitis
		Pleurisy
		Difficulty breathing
		Shortness of breath
		Shortness of breath lying down

CARDIOVASCULAR

		Heart disease
		High/low blood pressure
		Blood clots
		Phlebitis
		Rheumatic fever
		Swelling in ankles

		Angina
		Murmurs
		Fainting
		Palpitations/Fluttering
		Chest pain
		High Cholesterol

GASTROINTESTINAL

		Trouble swallowing
		Reflux
		Heartburn
		Vomiting blood
		Nausea
		Change in appetite
		Vomiting
		Belching or passing gas
		Ulcer
		Hemorrhoids

		Constipation
		Diarrhea
		Blood with stool
		Change in bowel movements
		Abdominal pain or cramps
		Gallbladder disease
		Black stools
		Colon Polyps
		Jaundice
		Liver disease

URINARY

		Pain on urination
		Increased Frequency
		Frequent infections

		Frequency at night
		Inability to hold urine (urgency)
		Kidney stones

MUSCULOSKELETAL

	Joint pain or stiffness
	Broken bones
	Muscle spasms or cramps

	Arthritis
	Weakness
	Sciatica

BLOOD/PERIPHERAL VASCULAR

	Easy bleeding or bruising
	Deep leg pain
	Varicose veins

	Anemia
	Cold hands/feet
	Thrombophlebitis

FEMALE REPRODUCTION/BREASTS

Age of first menses _____ Length of cycle _____
 Duration of Menses _____ Age of last menses (if menopausal) _____
 Date of last annual exam/ PAP (M/D/Y) _____

	Irregular cycles
	Bleeding between cycles
	Cramping with menses
	Premenstrual Syndrome
	Clotting
	Heavy or excessive flow
	Vaginal Discharge
	Menopausal Symptoms
	Breast lumps
	Breast pain/tenderness
	Nipple discharge

	Abnormal PAP
	Cervical Dysplasia
	Endometriosis
	Ovarian cysts
	Uterine Fibroids
	Sexually Active
	Painful Intercourse
	Sexual difficulties
	Sexually Transmitted Disease
	Birth Control: type _____
	Difficulty conceiving

Number of pregnancies _____ Number of live births _____
 Number of miscarriages _____ Number of abortions _____
 Do you do breast self exam? _____ Have you had a hysterectomy? _____

MALE REPRODUCTION

	Hernias
	Testicular masses
	Testicular pain
	Prostate disease
	Sexually Active

	Sexually Transmitted Disease
	Discharge or sores
	Impotence
	Premature ejaculation
	Birth Control: Type _____

CONTEXT OF CARE

What expectations do you have from this visit to our clinic?

What long-term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

Thank you for your time in providing this information.

We look forward to serving you in the best ways we are able.

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