Vancouver Thyroid Center
Patient Profile

Health History Questionnaire

Naturopathic health care and preventative medicine is most effective when a complete understanding of the patient is reached. Please fill out this form as thoroughly as possible and leave blank anything you are not sure of.

PERSONAL INFORMATION

Last Name: ________________________________ First Name: ______________________________

Age: _________ Date of Birth (mo/day/year): ________________ Sex: M F Other

Address: ____ City: ______________________

Postal Code: ______________________ Email: ____

Telephone (cell): ______________________ Telephone (alternate): _____________________________

Occupation: _______________________________________

Are you: Married Separated Divorced Significant Partnership Single Other

Who do you live with? ____

When and where did you last receive medical care? ____

What for? ____

What are your most important health concerns?

1. ____
2. ____
3. ____
4. ____
5. ____

How did you hear about Dr. Luis? ____

HOSPITALIZATION AND/OR SURGERY

Please list any hospitalizations or surgeries that and when ___________________________________

____

FAMILY HISTORY Please check off any applicable medical history and state the relationship (eg father)

_____Cancer
_____ Diabetes
_____ Heart Disease
_____ High Blood Pressure
_____ Stroke
_____ Mental Illness
_____ Asthma, Hayfever, Hives
_____ Anemia
_____ Auto-immune disorder
_____ Thyroid disorder
_____ Other: ____

IMMUNIZATIONS

Immunized as a child	N	Y
Annual Flu Vaccination	N	Y

ALLERGIES

Please list any foods, drugs or environmental allergens.

____

____

CURRENT MEDICATIONS - circle if you take the following:

Laxatives	N	Y	Pain Relievers	N	Y	Antacids	N	Y
Sleeping pills	N	Y	Cortisone	N	Y	Thyroid Rx	N	Y

List **ALL** prescriptions, over the counter medications, supplements and vitamins that you are taking with the dose.

1. _________________________________ 2. ____________________________________
3. _________________________________ 4. ____________________________________
5. _________________________________ 6. ____________________________________
7. _________________________________ 8. ____________________________________

THYROID

Diagnosis ________________________________ When __________________________________

Have you tried other thyroid medications? If so, what? ____

Have you had a thyroid ultra sound? __________

Do you have any other diagnosed conditions? ____

Have you ever had mono? If so, when? ____

Are you under the care of an endocrinologist? Who? _______________________________________

Additional information pertaining to your thyroid (optional) _____________________________________

____

____

PLEASE ANSWER : N = Never, **P** = Condition had in the past, **Y** = Condition you have now.

GENERAL

Weight	______________		
Max. Weight	______________		
When?	______________		
Height	______________		
Last Physical Exam	______________		
Fatigue	N	P	Y
Headache	N	P	Y

SKIN

Acne	N	P	Y
Colour changes	N	P	Y
Eczema, Hives	N	P	Y
Itching	N	P	Y
Night Sweats	N	P	Y

EYES

Glasses or Contacts	N	P	Y
Eye Pain	N	P	Y
Tearing or Dryness	N	P	Y
Double Vision	N	P	Y
Eye Disease	N	P	Y

EARS

Impaired Hearing	N	P	Y
Ringing	N	P	Y
Earache	N	P	Y
Ear Infections	N	P	Y
Vertigo/Dizziness	N	P	Y

NOSE AND SINUS

Frequent Colds	N	P	Y
Nose Bleeds	N	P	Y
Stuffiness	N	P	Y
Hay Fever	N	P	Y
Sinus Problems	N	P	Y

MOUTH AND THROAT

Frequent Sore Throat	N	P	Y

NEUROLOGIC

Fainting	N	P	Y
Seizures	N	P	Y
Paralysis	N	P	Y
Muscle Weakness	N	P	Y
Numbness/Tingling	N	P	Y
Loss of Memory	N	P	Y
Eyelid Twitch	N	P	Y

RESPIRATORY

Chronic Cough	N	P	Y
Excess Phlegm	N	P	Y
Wheezing	N	P	Y
Asthma	N	P	Y
Bronchitis	N	P	Y
Pneumonia	N	P	Y
Shortness of breath	N	P	Y

CARDIOVASCULAR

Angina or Chest Pain	N	P	Y
High Blood Pressure	N	P	Y
Low Blood Pressure	N	P	Y
Heart Disease	N	P	Y
Murmurs	N	P	Y
Swelling in Ankles	N	P	Y
Palpitation/Flutter	N	P	Y

GASTROINTESTINAL

Trouble Swallowing	N	P	Y
Heartburn	N	P	Y
Change in Thirst	N	P	Y
Change in Appetite	N	P	Y
Nausea/Vomiting	N	P	Y
Daily Bowel Movement	N	P	Y
How often?	_________ / day		
Is this a change?		N	Y
Pencil-Thin Stools	N	P	Y
Blood in Stool	N	P	Y

Gum Problems	N	P	Y
Hoarseness	N	P	Y
Sore Tongue	N	P	Y

NECK

Lumps	N	P	Y
Pain	N	P	Y
Swollen Glands	N	P	Y

URINARY

Pain on Urination	N	P	Y
Increased freq. in day	N	P	Y
Increased freq. in night	N	P	Y
Inability to hold urine	N	P	Y
Frequent Infections	N	P	Y
Kidney Stones	N	P	Y

ENDOCRINE

Hot flashes	N	P	Y
Excessive Thirst	N	P	Y
Sugar Cravings	N	P	Y

FEMALE REPRODUCTIVE

Are you pregnant?	N	P	Y
Age menses began	_______________		
Cycle Length (days)	_______________		
Number of days of flow	_______________		
Bleeding between menses	N	P	Y
Regular cycles	N	P	Y
Menopausal symptoms	N	P	Y
Pain with intercourse	N	P	Y
Excessive flow	N	P	Y
Birth Control	N	P	Y
Which Type?	_______________		
# of pregnancies	_______________		
# of live births	_______________		
Difficulties conceiving	N	P	Y
Are you sexually active?	N	P	Y
Sexual Difficulties	N	P	Y
Abnormal PAPS	N	P	Y
Last PAP test	_______________		
Sexually transmitted infections	_______________		
Excess discharge	N	P	Y
Sexual orientation (optional)	_______________		
Breast pain/tenderness	_______________		
Breast/Nipple discharge	N	P	Y
Do you self exam?	N	P	Y
Have you had a mammogram?	N		Y
Mammogram results	_______________		

Mucus in Stool	N	P	Y
Undigested food stool	N	P	Y
Brown Stool	N		Y
Abdominal Pain	N	P	Y
Liver/Gall Bladder disease		N	Y
Ulcer	N	P	Y
Hemorrhoids	N	P	Y
Food Poisoning	N	P	Y

MALE REPRODUCTIVE

Hernias	N	P	Y
Testicular mass/pain	N	P	Y
Are you sexually active?		N	Y
Sexual Difficulties	N	P	Y
Venereal Disease	N	P	Y
Discharge/Sores	N	P	Y
Sexual orientation (optional) ____________			

CIRCULATORY /BLOOD

Cold hands/feet	N	P	Y
Varicose veins	N	P	Y
History of Blood Clots	N	P	Y
Anemia	N	P	Y
Bruise easily	N	P	Y

EMOTIONAL

Depression	N	P	Y
Mood swings	N	P	Y
Anxiety/Nervousness	N	P	Y
Emotionally numb	N	P	Y
Treated for above	N	P	Y

HABITS

Do you eat 3 meals/day?		N	Y
How often do you exercise?		______/week	
Do you fall asleep well?	N	P	Y
Do you stay asleep?	N	P	Y
Do you awake rested?	N	P	Y
Average sleep per night		____/hours	
Enjoy your work	N	P	Y

MISCELLANEOUS

Date of last antibiotics use _____________			
Tropical vacation dates _______________			
Past history of cancer	N		Y
Recreational drug use	N	P	Y
Treated for addictions	N	P	Y
Use tobacco	N	P	Y
Alcohol drinks per week _______________			
Coffee/caffeine per day _______________			

Vancouver Thyroid Center – A division of Vitalia Health Care
Suite 460-2184 West Broadway, Vancouver, BC, V6K 2E1
Ph: 604-566-9355 Fax: 604-566-9357 Email: info@vitaliahealthcare.ca

DIET RECALL Please list the types of foods you eat on a typical day

Breakfast: ____

Snack: ____

Lunch: ____

Snack: ____

Dinner: ____

Food Cravings: ____________________ Water intake per day: ____________________