Dr. Penny Seth-Smith N.D.

Naturopathic Family Physician with Prescriptive Authority
Certifications in Acupuncture, Oral Chelation & Facial Mesotherapy

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Patient Information

Name_____ Age_____ M ☐ F ☐ Date_____

Street Address_____ Birthdate _____

City_____ Province _____Postal Code_____ Home Phone _____

Occupation_____ email (optional)_____

Work Phone _____Cell phone_____

Marital status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Name of Spouse / Partner _____ Types of pets _____

Children (Names / Ages)_____

If patient is a child: Mother's name _____

Father's name _____

How did you learn about this clinic? Friend ☐ Relative ☐ Professional ☐ Other ☐

If other, please describe _____ If referred, by whom? _____

Are you familiar with the services offered by Naturopathic Doctors? Yes ☐ No ☐

Have you had previous naturopathic care? Yes ☐ No ☐ If yes, When?_____

With whom?_____ For what ailments?_____

Other Health Care Providers: Medical Doctor(s) _____

_

Chiropractor _____Others _____

_____

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HEALTH QUESTIONNAIRE

Please answer all questions carefully. This information is necessary for Dr. Penny Seth-Smith to assess your total health picture as it relates to your current problem. It is a confidential record of your medical history and will not be released to any other person without your authorization.

Your Main Health Concerns

Please describe your major complaint(s): 1._____
2. _____ 3. _____
4. _____ 5. _____

When did the condition(s) begin? _____

Describe the pain or discomfort _____

What movements or circumstances aggravate the conditions (e.g. bending, damp, anger)
_____

Have you had the condition(s) before? No ____ If yes, when? _____

Please list doctors seen, treatments used and results achieved for the above conditions

What other measures have you tried, with what results?

Is your health currently getting better, worse, or staying the same? How do you know?

What do you feel is your weakest organ system, and why?

How frequently do you have a full and complete bowel movement?

Have you taken antibiotics? If yes, most recent date:

How frequently do you have a cold, sinusitis, flu, sore throat, or bronchitis?

How long do they usually last and are they severe?

Have you ever fainted, blacked out or had a convulsion?

Do you wear a medicalert bracelet or tag? If so, why?

Any severe allergies? If so, to what?

Please list the five most significant, stressful events in your life, and whether they continue to impact your life:

Your past medical history	Please tick

- ☐ Abscesses
- ☐ alcoholism
- ☐ allergies
- ☐ amnesia
- ☐ anemia
- ☐ ankylosing spondylitis
- ☐ arthritis: osteo/rheumatoid
- ☐ asthma
- ☐ auto-immune disease
- ☐ cancer
- ☐ candida
- ☐ chicken pox
- ☐ chlamydia
- ☐ cold sores
- ☐ cystitis
- ☐ depression
- ☐ diabetes/ high blood sugar
- ☐ diptheria
- ☐ ear infections
- ☐ emphysema
- ☐ epilepsy
- ☐ fibroids or cysts
- ☐ gallstones
- ☐ GERD / heartburn
- ☐ gonorrhea
- ☐ gout
- ☐ hayfever
- ☐ heart disease
- ☐ hepatitis
- ☐ herpes genitalia
- ☐ high blood pressure
- ☐ hiv/aids
- ☐ hives
- ☐ hypoglycemia
- ☐ IBS: irritable bowel
- ☐ influenza
- ☐ kidney disease
- ☐ kidney stones
- ☐ leukemia
- ☐ malaria
- ☐ measles: German
- ☐ measles red
- ☐ mercury fillings
- ☐ migraines
- ☐ miscarriage
- ☐ mononucleosis
- ☐ mumps
- ☐ osteopenia
- ☐ osteoporosis
- ☐ parasites / worms
- ☐ pelvic inflammatory disease
- ☐ pleurisy
- ☐ pneumonia
- ☐ prostatitis
- ☐ rheumatic fever
- ☐ rheumatism
- ☐ scarlet fever
- ☐ sexual abuse
- ☐ seizures
- ☐ shigella
- ☐ sinusitis
- ☐ skin disease
- ☐ strep throat
- ☐ sunstroke
- ☐ stroke
- ☐ syphilis
- ☐ thyroid disease/ goitre
- ☐ tonsillitis
- ☐ tuberculosis
- ☐ typhoid fever
- ☐ venereal warts
- ☐ warts elsewhere
- ☐ whooping cough

Any other major condition or hospitalisation? _____

Significant traumas (auto accidents, falls etc.) _____

Surgeries (please list and date)

_____

Please indicate if you have never been totally well after any of the above conditions, or if they were more severe than usual.

Family History: please indicate family member, and F if father's side, M if mother's side.

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestive disorders (chronic)
- ☐ Gonorrhea
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Syphilis
- ☐ Thyroid disease/goitre
- ☐ Tuberculosis
- ☐ Other major illness

Occupational Stress (chemical, physical, psychological)

Weekly Exercise

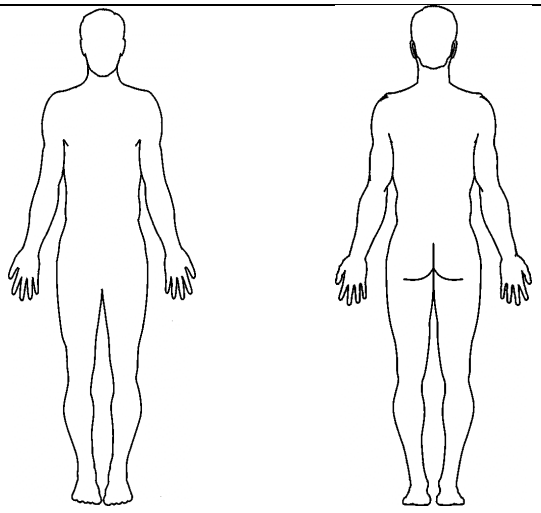
Medications: Please include prescription drugs, over the counter drugs, vitamins, minerals, herbs and any non-medical drugs you presently use, and any you have taken in the past for more than 3 months. Use a separate sheet if necessary.

What vaccinations have you had?
Did you suffer any adverse effects from them?

Diet

Are you or have you ever been on a restricted or specialised diet?
If so, what kind?
How many cups of tea ____ coffee ____ pop ____alcohol ____ do you drink per week?
Do you smoke? No If yes : How many per day: Cigarettes_____Cigars _____
Pipe_____ Other_____

Please Indicate Painful or Distressed Areas on the Diagram Below



Please indicate whether the following symptoms are current (please tick) or Past (P)

General

- ☐ Poor appetite
- ☐ Poor sleep
- ☐ Change in appetite
- ☐ Chills
- ☐ Fatigue
- ☐ Other
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Cravings
- ☐ Fevers
- ☐ Peculiar tastes or smells
- ☐ Weight gain (how much?)
- ☐ Weight loss
- ☐ Strong thirst
- ☐ Bleed or bruise easily
- ☐ Sudden energy drop - if regular, at what time?

Skin and Hair

- ☐ Eczema
- ☐ Psoriasis
- ☐ Other rashes
- ☐ Change in hair or skin texture
- ☐ Pimples
- ☐ Recent moles
- ☐ Ulcerations
- ☐ Loss of hair
- ☐ Dandruff
- ☐ Itching
- ☐ Other skin or hair problems

Head, Eyes, Ears, Nose and Throat

- ☐ Headaches (when & where?)
- ☐ Head or neck problems
- ☐ Concussions
- ☐ Eye strain
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Eye pain
- ☐ Colour blindness
- ☐ Blurry vision
- ☐ Cataracts
- ☐ Earaches
- ☐ Glasses
- ☐ Night blindness
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Facial pain
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Other

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heartbeat
- ☐ Dizziness
- ☐ Fainting
- ☐ Chest Pain
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Other

Respiratory

- ☐ Difficulty breathing
- ☐ Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Pain with a deep breath
- ☐ Production of phlegm (colour?)
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Other

Gastrointestinal

- ☐ Indigestion
- ☐ Gas
- ☐ Bad breath
- ☐ Constipation
- ☐ Known/suspected parasites
- ☐ Abdominal pain or cramps
- ☐ Nausea
- ☐ Vomiting
- ☐ Regular laxative use
- ☐ Ulcer
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ Other digestive symptoms

Genito-Urinary

- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Pain on urination
- ☐ Do you wake to urinate?
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Any particular colour
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Impotence
- ☐ Sores on genitals
- ☐ Other problems

Gynecology and Pregnancy

_____Age of first period
_____Duration of flow
_____Days between periods (start to start)
_____Date of last period
_____Date of last PAP exam
_____Date of last mammogram

- ☐ Changes in body or emotions before period
- ☐ Hot Flashes
- ☐ Do you use birth control?

Unusual menses:

- ☐ Heavy
- ☐ Light
- ☐ Clots
- ☐ Other

- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Yeast infections
- ☐ Breast tenderness
- ☐ Breast lumps

What type_____ for how long?_____

Number of pregnancies____ Number of births____ Miscarriages____
Abortions_____

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pain
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Other joint or bone problems
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Other muscle problems

Neuropsychological

- ☐ Loss of balance
- ☐ Quick temper/irritable
- ☐ Poor memory
- ☐ Anxiety
- ☐ Depression
- ☐ Susceptible to stress
- ☐ Dizziness
- ☐ Lack of co-ordination
- ☐ Concussion
- ☐ Seizures
- ☐ Areas of numbness
- ☐ Other

Travel History

To what countries have you travelled? _____

Were you ill there or shortly after your return? _____

Mental / Emotional History

Have you ever been treated for emotional problems? _____

If so, what kind of treatment?_____

Have you ever considered suicide or attempted it ?

Any other neurological problems?_____

Any other psychological problems?_____

Anything else?

Please describe any other problems or situations you would like to discuss.

PLEASE NOTE

Please bring this completed form with you to your first visit.

Copies of any recent test results from other health care professionals are helpful. Please bring these with you whenever possible.

Missed visits and cancellations less than 24 hours before the appointment time will be charged at half of the visit fee, as this time has been set aside for you. If you need to cancel or reschedule, please give as much notice as possible.

I accept payments by cash, cheque, Debit, VISA or MasterCard. Payment is due at the end of the visit.

My office is "fragrance free", as some patients are sensitive to perfumes and colognes. If you like to wear scents, please refrain from using them until after your appointments.

THANK YOU