David Miller
Naturopathic Doctor

PATIENT INFORMATION FORM

PATIENT INFORMATION		
First Name:	Last Name:	Middle Name:
Sex: ☐ M ☐ F	Date of Birth: (DD/MM/YYYY)	
Occupation:		
Marital Status:	Number in household:	
CONTACT INFORMATION		
Street Address:		City:
Postal Code:	Home Phone:	Mobile Phone:
May we leave messages concerning your visits?: ☐ Yes ☐ No	Email Address:	
EMERGENCY CONTACT INFORMATION		
1. Last Name	First Name	Relationship
Daytime Phone Number:	Evening Phone Number:	
2. Last Name	First Name	Relationship
Daytime Phone Number:	Evening Phone Number:	

Would you like to join our mailing list and receive newsletters?

☐ Yes ☐ No

Where did you hear of the clinic of David Miller ND?

☐ Friend referral ☐ Other health practitioner ☐ CAND ☐ OAND
☐ Internet search ☐ Walk/drive by ☐ Print advertising ☐ other

OTHER HEALTH CARE PRACTITIONERS

1. Name and Designation		2. Name and Designation		3. Name and Designation	
1. Specialty/Focus		2. Specialty/Focus		3. Specialty/Focus	
1. Phone	Fax	2. Phone	Fax	3. Phone	Fax

HEALTH HISTORY QUESTIONNAIRE

These questions are strictly confidential and will be kept as part of your medical record

Date of last visit to medical doctor:

Are you currently under his/her care?
☐ Yes ☐ No

Please list regular screening tests done by other physicians (PAP test, blood tests, physical screening tests etc):

Date of last physical exam:

Have you seen a Naturopathic Doctor before?
☐ Yes ☐ No

Immunizations:

☐ Tuberculosis ☐ Tetanus ☐ Hepatitis A
☐ DPT (diptheria, polio, tetanus) ☐ Smallpox ☐ Hepatitis B
☐ Chickenpox ☐ MMR (measles, mumps, rubella) ☐ Influenza (flu shot)

Did any of these cause an adverse reaction? Please explain below.

Childhood Illnesses:

☐ measles ☐ mumps ☐ scarlet fever ☐ chickenpox ☐ polio ☐ frequent infections
☐ other (please describe)

History of previous illnesses
Please list any other conditions that other doctors have diagnosed:

1.

2.

3.

4.

5.

6.

Surgeries

Year	Type of surgical procedure	Reason for procedure

Other Hospitalizations

Year	Reason for hospitalization

Environmental medical history:
Have you ever been exposed to any known or suspected toxic substances as a part of your job or otherwise? Please describe.

Antibiotic use:
How many times have you used antibiotic medications in the past 5 years? For what condition(s)?

Allergic History:
Please list all allergens (food, drug, supplement, environmental):

Allergen	Reaction you experience

Female Patients only:
Difficulties in conceiving? ☐ yes ☐ no

Pregnancies	Births	Miscarriages	Abortions

CHRONOLOGICAL HEALTH HISTORY

Please list any of the following: accidents, broken bones, falls, illnesses, hospitalizations, surgeries, and/or any emotional stresses or traumas (deaths, loss of job, divorce, etc.).

Age 0-5	

Age 5-10	
Age 10-20	
Age 20-30	
Age 30-40	
Age 40-50	
Age 50-60	
Age 60+	

FAMILY MEDICAL HISTORY

INCLUDING: ALLERGIES, ASTHMA, HEART DISEASE, HIGH BLOOD PRESSURE, CANCER, DIABETES, DEPRESSION, OTHER MENTAL ILLNESS, DRUG ABUSE, ALCOHOLISM, KIDNEY DISEASE AND ANY OTHER RELEVANT HEALTH PROBLEMS.

Relation M = maternal P = paternal	Age	Illnesses	Cause, if deceased
☐ M ☐ P			
☐ M ☐ P			
☐ M ☐ P			
☐ M ☐ P			
☐ M ☐ P			
☐ M ☐ P			

PERSONAL HEALTH HABITS AND SAFETY

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Height	**Weight**	Weight 1 yr ago	Max weight (year)

Fluid intake/day	**Water** intake/day	**Alcohol**
		☐ Don't drink ☐ Daily ☐ > 20/week How many years have you: Drunk? ________________ Been alcohol-free? _______________

Tobacco

☐ Smoke ☐ Don't smoke ☐ Exposed (2nd hand)

How many years have you smoked, or did you smoke consecutively in the past? _____________

Recreational Drug Use

☐ Yes ☐ No Frequency of use? ______________

What kind of recreational drug? _____________________________

Caffeine

☐ Yes ☐ No Frequency of use? ______________

Form (coffee, tea, soda) ____________________________________

Sexual Habits

Are you sexually active? ☐ Yes ☐ No

Are you trying to conceive? ☐ Yes ☐ No

Any contraceptive measures? ☐ Yes ☐ No

Type of contraceptive __________________________________

Any discomfort during intercourse? ☐ Yes ☐ No

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Movement and Exercise

Sedentary (no exercise) ☐ Mild exercise (walk ~30 mins/day) ☐ Rigorous (gym ≥ 3X/week ☐

Social

Stress level? ☐ Low ☐ Med ☐ High

What is the main source of your stress?
☐ family ☐ financial ☐ health ☐ occupation ☐ other

How do you cope with stress?

Do you have a social support network? (Friends, community) ☐ Yes ☐ No

Diet

Are you on any type of diet? ☐ Yes ☐ No

Is this diet a recommendation of a physician or other practitioner? ☐ Yes ☐ No

Dietary restrictions? (vegan, vegetarian, religious) ☐ Yes ☐ No

Rank salt intake ☐ Low ☐ Med ☐ High

Rank fat intake ☐ Low ☐ Med ☐ High

Rank carbohydrate/sugar intake ☐ Low ☐ Med ☐ High

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MEDICATIONS		
List your *current* prescribed drugs, over-the-counter medications and supplements, and those that you have taken in the past for *over 3 months*		
Medication/supplement	**Start**	**Stop**
1.		
2.		
3.		
4.		

Thank you for taking the time to fill out this form. Your honesty and effort in doing so will be of great help to you and your physician.

Please indicate if there is anything else that you think is pertinent to your health and well-being.

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