

Dr. Sid Weiss, Naturopathic Physician

Confidential Patient Health Profile

Today's Date: _____

Name: _____ Age: _____ Birth date: _____ Sex: F_ M_

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____

Care Card No: _____ Profession: _____

Employer: _____ Employed full or part time: _____

Email Address: _____

Marital Status: _____ Number of Children _____ M.D.Physician: _____

Emergency contact: _____ Relationship: _____ Phone: _____

How did you hear about Dr. Weiss? _____

Please list all drug medications that you are currently taking, prescription or over the counter

Please list all nutritional supplements, herbal, homeopathic medicines, etc., that you take

Allergies _____

Surgeries & Hospitalizations _____

CURRENT HEALTH CONDITION

What health concerns/problems brought you to this office today? _____

Has anything recently changed or become worse? _____

PERSONAL HEALTH HABITS:

Height: _____ Current Weight: _____ lbs. One year ago: _____ lbs. Maximum weight _____ lbs. in 19 _____

Smoker: _ Yes _ No Smoked _____ years Amount/day: _____ Year stopped: _____

Are you exposed to second hand smoke? ___ Do you use artificial sweeteners? Chew gum? _ Yes _ No

Alcohol Use: _ Yes _ No Type: _____ Frequency: _____

Recreational Drug Use: _ Yes _ No Type: _____ Frequency: _____

Coffee: _ Yes _ No _____ cups/day Tea: _ Yes _ No _____ cups/day Water: _____ cups/day

Purified water type _____ Tap water _____ Milk _____ Juice _____

Herbal Tea: _ Yes _ No _____ cups/day Soft Drinks: _ Yes _ No _____ 8oz servings/day

Diet: Any foods that you avoid: _ Yes _ No _____

Diet: Are there any foods that you tend to eat a lot of? _ Yes _ No _____

Diet: Do you consume dairy products? _ Yes _ No _____

On a scale of 1 to 10 with 10 being the highest, please rate your average STRESS level: _____

On a scale of 1 to 10 with 10 being the highest, please rate your average ENERGY level: _____

How many hours of sleep do you get a night? _____ Do you wake up feeling rested? _ Yes _ No _ Sometimes

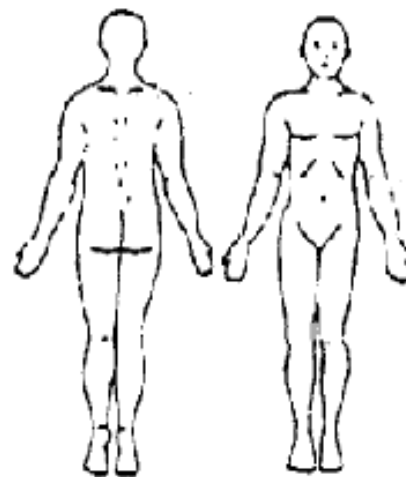
Regular exercise: _ Yes _ No Type: _____ Duration: _____ Frequency: _____

Women: Are you currently pregnant? _ Yes _ No _ Not Sure

Type of Birth Control Used: _____ If history of Birth Control Pill use, how many years? _____

MEDICAL HISTORY: Please check only those that pertain to YOU personally.

- | | |
|------------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gall Bladder / Liver Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gum / Teeth Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Bladder / Urinary Problems | <input type="checkbox"/> Head Injury / Serious Injury |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Heart Disorders |
| <input type="checkbox"/> Blood Pressure Problems / Stroke | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Frequent colds, flu, sore throats | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Digestive Disturbances | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Occupational Exposure to Toxic Substances |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Psychological - anxiety / depression / suicidal |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sexually Transmitted Diseases
(Herpes, Chlamydia, Gonorrhea) |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Fatigue, Chronic | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Female Gynecological Problems | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Mononucleosis | |



Please outline on the diagram the area of your discomfort.

FAMILY MEDICAL HISTORY: Please check relative areas for blood relatives *NOT* including yourself.

- | | | | |
|--------------------------------------------|-----------------------------------------------|-------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Obesity | |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Hay fever, Allergies | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Substance Abuse | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid Problems | |

Thank you

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