BIHC | Belleville Integrative Health Centre

WORKING TOGETHER FOR YOUR HEALTH

Dr. Kelly Gillis, ND
Doctor of Naturopathic Medicine

Patient Information

Date of initial appointment: DD/MM/YYYY

Name: ____

Address: ____

____

Age: _____ Date of Birth: DD/MM/YYYY Sex: ☐ M ☐ F

Gender (if different than sex): ______________________

Occupation:____

Employer: ____

Emergency contact name: ____________________________

Relationship: ______________________________________

Emergency contact phone number: (____)___________

1 - Phone #: (___)__________________

☐ Home ☐ Work ☐ Cell

2 - Phone #: (___)__________________

☐ Home ☐ Work ☐ Cell

Email: ___________________________

Preferred method of contact:

☐ Phone (1 or 2)

☐ Email

☐ Do not contact

May we leave messages regarding your visit? ☐ Yes ☐ No

How did you hear about the BIHC: ____

If you were referred, please state by whom:____

Have you ever been treated by a naturopathic doctor before: ☐ Yes ☐ No

If yes, by whom:____ Date of last visit: DD/MM/YYYY

Date of last physical exam: DD/MM/YYYY

Health Goals

Please list your major health concerns/goals in order of importance:

1.____

2.____

3.____

4.____

5.____

BIHC | 777 Bell Boulevard, Belleville ON **Email**: info@bihc.ca **Phone**: 613.966.9500 | **Fax**: 613.966.9590

Medical History

Please indicate any serious illnesses/injuries/hospitalizations with approximate dates:

1.____________________________________

2. ___________________________________

3. ___________________________________

4. ___________________________________

5. ___________________________________

6. ___________________________________

7. ___________________________________

8.___________________________________

Childhood illnesses (check all that apply):

☐ Asthma
☐ Scarlet fever
☐ Rheumatic fever
☐ Rubella (German measles)
☐ Chicken pox
☐ Polio
☐ Whooping cough
☐ Mumps
☐ Measles
☐ Roseola

Vaccination history (Bolded vaccines are considered routine as per the Ontario Childhood Vaccination schedule) check all that apply:

☐ **DPT (Diptheria, Pertussis, Tetanus)**
☐ **MMR (Measles, Mumps, Rubella)**
☐ **Hepatitis B**
☐ **Polio**
☐ **Pneumococcal conjugate (meningitis / pneumonia)**
☐ **Meningococcal C Conjugate (meningitis)**
☐ **Varivax / Varilrix (chicken pox)**
☐ Gardasil / Cervarix (HPV vaccine)
☐ Haemophilus Influenza B
☐ BCG (Tuberculosis)
☐ Hepatitis A
☐ Flu vaccine
☐ Other: _________________________

List any CURRENT medications, including over the counter medications, supplements, vitamins, minerals, herbs and homeopathics:

Medication/supplement name	Dose and Brand

List any PAST medications, including over the counter medications, supplements, vitamins, minerals, herbs and homeopathic remedies:

Medication/supplement name	Dose and Brand	Start date	Stop date

List all ALLERGIES including environmental, food, pharmaceutical/supplement, etc. and describe your reaction:

Allergy	Reaction

Indicate if you currently have, or have had in the past, any of the following by checking all applicable boxes. Please provide the approximate date:

☐ AIDS/Positive HIV ______________
☐ Allergies ______________
☐ Anemia ______________
☐ Anxiety ______________
☐ Asthma ______________
☐ Arthritis ______________
☐ Colitis ______________
☐ Convulsions/Seizures ______________
☐ Depression ______________
☐ Diabetes ______________
☐ Eating Disorder ______________
☐ Eczema ______________
☐ Endometriosis ______________
☐ Headaches/migraines ______________
☐ Heart Disease ______________
☐ Heart Murmur ______________
☐ Hepatitis ______________
☐ High Blood Pressure ______________
☐ Hyperthyroidism ______________
☐ Hypothyroidism ______________
☐ Urinary tract infections ______________
☐ Kidney/Bladder Infections______________
☐ Other mental illness not listed ______________
☐ Mononucleosis ______________
☐ Abnormal PAP results ______________
☐ Polio ______________
☐ Psoriasis ______________
☐ Prostate Condition ______________
☐ Rheumatic Fever ______________
☐ STI ______________
☐ Stomach/Duodenal Ulcer______________
☐ Tuberculosis ______________
☐ Urinary Tract Infections ______________
☐ Vaginitis ______________
☐ Other ______________
☐ Other ______________
☐ Other ______________

Family Medical History

Check any known health concerns for each family member and write in which family member(s) has been affected. List any other known health concerns in the table below:

- ☐ Cancer (type _________) _______________
- ☐ Diabetes (Type 1/Type 2)_______________
- ☐ Heart disease _______________
- ☐ Depression _______________
- ☐ Anxiety _______________
- ☐ Other mental illness _______________
- ☐ High blood pressure _______________
- ☐ Stroke _______________
- ☐ Thyroid problems _______________
- ☐ Autoimmune disease _______________
- ☐ Kidney disease _______________
- ☐ Alcohol/drug abuse _______________

Mother	
Father	
Siblings	
Maternal grandmother	
Maternal grandfather	
Paternal grandmother	
Paternal grandfather	

Diet and Lifestyle

Diet	List any dietary restrictions or allergies:	
	24hr diet recall: Breakfast: ___________ Lunch: ___________ Dinner: ___________ Snacks: ___________ Beverages: ___________	
Caffeine	Number of cups of the following consumed in a day: Coffee: ________ Tea: _______ Juice: _________ Cola: ________	
Alcohol	Do you consume alcohol? ☐ Yes ☐ No	If yes, how many drinks per week?
	What type(s) of alcohol do you consume?	
Tobacco	Do you use tobacco? ☐ Yes ☐ No	If yes, how many times per day?
	What type(s) of tobacco?	How many years?
	Have you even been exposed to second hand smoke for extended or regular periods? ☐ Yes ☐ No	If yes, for how long?
	Do you use recreational drugs? ☐ Yes ☐ No	

Drugs	If yes, which kind(s) and how often?		
Exercise	How many times per week do you exercise? 0 1 2 3 4 5 6 7 >7		
	What type of exercise do you prefer?		
Stress	Rate your stress from 0-10 (0 = no stress, 10 = extremely stressful) 0 1 2 3 4 5 6 7 8 9 10		
	What are the major sources of stress in your life:		
Energy	Rate your energy from 0-10 (0 = no energy, 10 = most energetic) 0 1 2 3 4 5 6 7 8 9 10		
	Time of day for best energy:		Time of day for lowest energy:
Sleep	What are your typical sleeping hours? From __________ am/pm to __________ am/pm		
	Do you have trouble falling asleep? ☐ Yes ☐ No		Do you awake feeling refreshed: ☐ Yes ☐ No
	Do you have trouble staying asleep? ☐ Yes ☐ No		What times do you wake up during the night?
Relationships and sexuality	Sexual orientation:		
	If female:	Are you currently pregnant? ☐ Yes ☐ No	Are you currently breastfeeding? ☐ Yes ☐ No
Lifestyle	What types of hobbies and activities do you do?		
	Where have you travelled?		
	Do you have any pets, or are you exposed to any animals?		