POLO
HEALTH + LONGEVITY CENTRE

Health History Questionnaire

All information included here will be *absolutely confidential*. If you have any questions please ask. Thank you.

Name_____ Age _____ M ☐ F ☐ Today's Date _____

Your Care Card Number_____ Birthdate (D/M/Y) _____

Home Address _____

City _____ Postal Code _____

Occupation _____

Work Phone _____ Home Phone _____

Spouse's Name_____ Children(Name/Age)_____

_____

E-mail Address

_____

I give permission to be emailed occasionally about specials or new treatments: Yes ☐ or No ☐

Names of Other Healthcare Providers:

Medical Doctors _____ Naturopathic Physician_____

Chiropractor_____ Others _____

How did you hear about our clinic?

_____

Do you have Extended Coverage? Yes ☐ No ☐

Do you receive MSP Premium Assistance? Yes ☐ No ☐

	Age	Health Problems	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Brother/Sisters				
Children				

Your Main Health Concern

What are your main health concerns? Please list in order of importance

1.

2.

3.

4.

5.

When did your problem(s) begin (be specific)?

What is your level of commitment to addressing underlying causes of your symptoms that are related to your lifestyle (10 being 100% committed)

1 2 3 4 5 6 7 8 9 10 write number _____

Family Medical History

Your Past Medical History (Please check and date)

☐ Cancer	☐ Diabetes	☐ Venereal Disease
☐ High Blood Pressure	☐ Seizures	☐ Surgeries
☐ Heart Disease	☐ Hepatitis/Kidney Disease	☐ Anemia (All types)
☐ High Cholesterol	☐ Anxiety	☐ Depression
☐ Thyroid Disease	☐ Osteoporosis/Osteopenia	☐ Arthritis
☐ Rheumatic Fever	☐ Asthma	☐ Other Major Illness

☐ Significant Trauma (auto accidents, falls, other)

(Specify) _____

☐ Allergies (drugs, chemicals, environmental, foods) (Specify)

_____

_____

Current Medications and Supplements

Please list prescriptions, over-the-counter drugs, vitamins and herbs with dose and start date

_____

_____

Social History

How many packs of cigarettes do you smoke a day?

How much alcohol do you drink per week?

Do you take any recreational drugs?

Are you exposed to any toxins or chemicals in your home or work (mold, chemicals, etc)?

Have you been vaccinated?

How often do you exercise?

Diet

Are you or have you ever been on a restricted diet? If so, what kind?

_____

Please describe your average daily diet:
Morning

_____

Afternoon

_____

Evening

_____

Please check if the following symptoms are a CURRENT or RECURRING PROBLEM.

General

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

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Eczema
- ☐ Acne
- ☐ Change in hair or skin texture
- ☐ Loss of hair
- ☐ Dandruff
- ☐ Recent moles
- ☐ Ulcerations
- ☐ Other hair or skin problems?

Head, Eyes, Ears, Nose and Throat

- ☐ Headaches
- ☐ Neck pain
- ☐ Concussions
- ☐ Eye pain
- ☐ Eye strain
- ☐ Blurry vision
- ☐ Using glasses
- ☐ Night blindness
- ☐ Colour blindness
- ☐ Cataracts
- ☐ Earaches
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Facial pain
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Jaw clicks or pain
- ☐ Tooth pain
- ☐ Mercury tooth fillings
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue

Heart and Circulation

- ☐ 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

Lungs and Breathing

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

Digestion and Elimination

- ☐ Indigestion
- ☐ Gas
- ☐ Bloating
- ☐ Constipation
- ☐ Bad Breath
- ☐ Abdominal pain or cramps
- ☐ Nausea
- ☐ Vomiting
- ☐ Chronic laxative use
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Diarrhea

Genito-Urinary

- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Pain on urination
- ☐ Do you wake to urinate?
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Distinctive or odd colour
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Impotency
- ☐ Sores on genitals
- ☐ Other problems

Women

- _____ Age of first menses
- _____ Duration of menses
- _____ Days between menses
- _____ Date of start of last menses
- _____ Date of last PAP exam
- ☐ Unusual menses
- ☐ Heavy
- ☐ Light
- ☐ Clots
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Do you perform a monthly self - breast exam?
- ☐ Changes in body or emotions prior to menstruation?
- ☐ Do you practice birth control? ☐ What type and for how long?

Number of pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Muscles, Joints and Bones

- ☐ 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

Brain, Nerves and Emotions

- ☐ Loss of balance
- ☐ Quick temper / irritable
- ☐ Poor memory
- ☐ Anxiety
- ☐ Depression
- ☐ Susceptible to stress
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Concussion
- ☐ Seizures
- ☐ Areas of numbness
- ☐ Have you ever been treated for emotional problems?
- ☐ Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

_____