King Liberty Health Centre
131 Jefferson Ave
Toronto, Ont.
M6K 3E4
647-350-2932
Fax: 416-516-5267

Dr. Ravinder Gill, N.D.

Doctor of Naturopathic Medicine

Health Questionnaire

Please help us provide you with a complete evaluation by carefully filling out this questionnaire. All of your answers will be held *absolutely confidential*. If you have any questions, please ask. Thank you.

Name: **Gender (circle): M F**

CURRENT MEDICAL HISTORY

Major complaints in order of importance for you?	Since

Current Medicines: (prescriptions, over the counter drugs, vitamins, herbs)

YOUR PAST MEDICAL HISTORY (include date)

- Allergies
- Asthma
- Cancer
- Diabetes
- Depression
- Heart Disease
- Hepatitis
- High blood pressure
- Frequent antibiotic use
- Rheumatic fever
- Seizures
- Stroke
- Thyroid disease
- Venereal disease
- HIV/AIDS
- Other

FAMILY MEDICAL HISTORY (use f-father, m-mother, b-brother, s-sister, father's parents –fgf or fgm, mother's parents –mgf or mgm

- Allergies
- Asthma
- Alcoholism
- Cancer
- Diabetes
- Depression
- Glaucoma
- High blood pressure
- HIV/AIDS
- Other
- Heart disease
- Hepatitis
- Rheumatic fever
- Seizures
- Stroke
- Thyroid disease
- Venereal disease
- Mental illness

YOUR PAST MEDICAL HISTORY

Surgeries?

Significant trauma (auto accidents, falls, etc.)?

Health as a child? Good Fair Poor

Any adverse reactions to vaccinations? Yes No

Allergies? (drugs, chemicals, foods)

Do you follow a regular exercise program? Yes No
If yes please describe:

Do you:	If yes:
Smoke	How many per day:
Drink coffee, tea or cola	How many per week:
Drink alcohol	How much per week:
Take any recreational drugs	Describe:

Have you ever had any dental work?
Describe.

Please describe your average daily diet:		
Morning	Afternoon	Evening

Indicate any painful or distressed areas below:

Please check if the following symptoms are currently a problem or a recurring problem?

GENERAL

Poor appetite	Poor sleep	Fatigue
Fevers	Night sweats	Chills
Sweat easily	Tremors	Cravings
Localized weakness	Bleed or bruise easily	Poor balance
Weight gain	Peculiar tastes/smells	Weight loss
Always feel hot	Always feel cold	
Strong thirst (cold or hot drinks)	Sudden energy drop (time of day)?	

SKIN AND HAIR

Rashes	Hives	Ulcerations
Itching	Eczema	Pimples
Dandruff	Recent moles/growths	Loss of hair
Changes in hair or skin texture	Warts	Other?

HEAD, EYES, EARS, NOSE & THROAT

Dizziness	Concussions/head injury	Migraines
Glasses/poor vision	Eye pain or strain	Blurry vision
Watery or dry/itchy eyes	Night blindness	Cataract
Earaches	Recurrent ear infections	Ringing in ears
Hearing loss	Sinus problems	Nose bleeds
Recurrent sore throats	Grinding teeth	Facial pain
Sores on lips/tongue	Teeth problems	Jaw clicks
Hay fever	Post-nasal drip	
Headaches (where and when)?		
Other head and neck problems?		

CARDIOVASCULAR

High blood pressure	Low blood pressure	Chest pain
Irregular heartbeat	Dizziness	Fainting
Cold hands or feet	Swelling of hands	Swelling of feet
Difficulty in breathing	Blood clots	Varicose veins
Any other heart or blood vessel problems?		

RESPIRATORY

Asthma	Bronchitis	Pneumonia
Pain with deep breath	Cough	Coughing blood
Production of phlegm (what colour)?		TB test ever
Difficulty breathing when lying down		Flu shot ever
Any other lung problems?		

GASTROINTESTINAL		
Bad breath	Indigestion/Heartburn	Nausea
Belching	Bloating	Gas
Diarrhea	Constipation	Rectal pain/itching
Vomiting	Black stools	Blood in stools
Abdominal pain or cramps	Gall stones	Chronic laxative use
Gall bladder removal surgery		
Any other problems with stomach or intestines?		

GENITO-URINARY		
Pain/burning on urination	Frequent urination	Blood in urine
Urgency to urinate	Unable to hold urine	Kidney stones
Impotency	Sores on genitals	Genital itching
Testicular pain or masses (males only)		
Do you wake to urinate (how often)?		
Any other problems with your genital or urinary system?		

GYNECOLOGY & PREGNANCY		
___ Age at first menses	___ Age menses stopped	__________ Last PAP
___ Number of pregnancies	___ Number of births	
___ Duration of menses (days)___ Days between menses		
Premature births	Abortions	Miscarriages
Painful menses	Light	Heavy
Clots	Irregular menses	
Vaginal discharge	Vaginal itching	Vaginal sores
Breast lumps	Breast pain/tendernesss	Nipple discharge
Hormone replacement therapy	Menopausal symptoms	
Changes in body/psyche prior to menstruation or PMS		
Do you practice birth control? What type and for how long?		

NEURO-PSYCHOLOGICAL		
Seizures	Loss of balance	Poor memory
Areas of numbness or tingling	Lack of coordination	Anxiety
Quick temper/irritable	Easily susceptible to stress	Depression
Have you ever been treated for emotional problems?		
Have you ever considered or attempted suicide?		
Any other neurological or psychological problems?		

COMMENTS

Please indicate any other problems you would like to discuss.

Dr. Ravinder Gill, N.D.
NATUROPATHIC DOCTOR
King Liberty Health Centre
131 Jefferson Ave
Toronto ON M6K 3E4
Tel: 647-350-2932

PATIENT INFORMATION

FULL NAME__________________________________BIRTHDATE_______________

AGE____ HOME PHONE ___________________________

WORK _________________________CELL ______________________

E-MAIL ______________________ MAY WE LEAVE MESSAGES AT THE ABOVE NUMBERS? ______________________

ADDRESS____

POSTAL CODE________________

PLACE OF BIRTH __________________________________ BLOOD TYPE ____________ MARITAL STATUS_______________________ NUMBER OF CHILDREN_____________ AGES__________________________

OCCUPATION____________________________ HOW LONG EMPLOYED _____________ EMPLOYER________________________

HOW DID YOU HEAR ABOUT OUR CLINIC (NAME OF PERSON WHO REFFERED YOU)? ____________________________

DO YOU HAVE EXTENDED HEALTH COVERAGE? _____________WHICH COMPANY? _____________________________

HAVE YOU HAD PREVIOUS NATUROPATHIC CARE? _________ WITH WHOM? ___________________________________

FOR WHAT REASONS? ____ DATE OF LAST VISIT______________ REASON FOR DISCONTINUING CARE ____

HEALTHCARE PRACTITIONERS	*NAME*	**PHONE NUMBER**	**DATE OF LAST VISIT**	**REASONS FOR CARE**
CHIROPRACTOR				
MEDICAL DOCTOR				
OTHER: __________ __________________				

All fees for services and supplements are the responsibility of the patient, payable in full, at the time of treatment. Payment can be made in the form of cash, personal cheque, Interac, Mastercard or VISA. Please note that *OHIP does not cover naturopathic services.* Many extended health care plans cover some or all of the naturopathic medical services; you will need to check the specifics of your plan. We will supply you with the necessary receipts to submit to your insurance company.

Please note: Your appointment is reserved for you. **We require notice of 24 hours for cancellation of an appointment**. If we do not receive sufficient notice, a fee will be incurred. This fee covers clinic costs and helps avoid the need to increase our consultation fees.

Signature: ____ Date: ______________________