

CLIENT PROFILE

Family Doctor:	
Name	_____
Address	_____
Telephone Number	_____
Fax Number	_____
Client's OHIP Number	_____

Client's Name _____ Email _____
Address _____
Phone Number _____ Work Number _____ Cell Number _____
Date of Birth Year _____ Month _____ Day _____ Age _____
Occupation: _____ Gender _____

PAST HISTORY/RISK FACTORS:

Have you had or do you have:

	Yes	No
High Blood Pressure	()	()
Diabetes	()	()
Asthma	()	()
Epilepsy	()	()
Heart Murmur	()	()
Heart Disease	()	()
Ulcer Disease	()	()
Blood Transfusion	()	()
Abdominal Disease	()	()
Hepatitis	()	()
Kidney Disease	()	()
Thyroid	()	()
Migraine	()	()
Chest Pain	()	()
Shortness of Breath	()	()
Cancer	()	()
Skin Disease	()	()
Psychiatric Problems	()	()

Please List Previous Operations, Injuries, & Ongoing Medical Problems

When _____

Pregnancy _____

ONGOING PSYCHOLOGICAL HEALTH CONDITIONS/SOCIAL HISTORY:

Smoking _____ Years _____
Alcohol Intake - Yes ___ No _____ Quantity _____
Other Substances or Addictions _____

LONG-TERM TREATMENT REGIMEN:

Have You Recently Taken These Medications:

	Yes	No
Aspirin/Tylenol	()	()
Blood Thinners	()	()
Birth Control Pills	()	()
Blood Pressure Pills	()	()
Diabetes Medications	()	()
Tranquilizers	()	()
Steroids/Cortisone	()	()
Heart Pills	()	()

Please List the Major Illnesses in Close Family Members, e.g. Diabetes, Heart Disease, High Blood Pressure, Cancer

Father _____
Mother _____
Brother/Sister _____
Grandparents _____
Children _____

WHAT MEDICATIONS ARE YOU NOW TAKING?

ANY ALLERGIES AND SENSITIVITIES?

What reaction did you have? _____

