Boucher Institute Naturopathic Medical Clinic
320-435 Columbia Street, New Westminster, BC V3L 5N8 (604)540-2873

Confidential Health History

Surname: _____ First name: _____

Birth Sex: Male ☐ Female ☐ Gender Identity:_____ Birthdate:_____

Address: _____ City: _____ Postal Code: _____

Primary phone number: _____ Secondary phone number: _____

Personal Health Number: _____ Occupation: _____

If you are under 18 years of age, please list the name, relationship, and contact information of the person who is legally responsible for you:

Name: _____ Relation: _____ _Phone: _____

How did you hear about the Boucher Clinic? _____

Would you like to receive our newsletter through email? Yes ☐ No ☐ Email:_____

Person to notify in an emergency:

Name: _____ Relation: _____ _Phone: _____

As a teaching clinic, we are unable to accept patients with outstanding medical or legal claims, including ICBC and WCB.
Do you have an outstanding claim? Yes ☐ No ☐

I understand that I am required to give a minimum of 24 hours notice if I am unable to make my appointment. In the event that I miss an appointment without sufficient notice, I may be charged the full cost of the missed appointment.

Signature: _____ Date: _____

Please list your health concerns:

_____
_____
_____
_____

Are you being treated by any other physician(s) or healthcare practitioners? If yes, please list the name(s) and phone number(s):

_____
_____

Height: _____ Current weight: _____ Weight one year ago: _____

Blood type: A ☐ B ☐ AB ☐ O ☐

Please list all of your prescription and non-prescription medications (including birth control pills, aspirin etc.):

_____
_____

Do you think that you may need to take supplements? Yes ☐ No ☐

Please list any vitamins, minerals, or other **supplements** you are taking, with dosages if known:

Please list any known **allergies** including medications, environmental, and food:

Are they any foods/food groups that you avoid? (Please list):

Please list any **hospitalizations**, **serious injuries**, and/or **surgeries**: (date and type):

Immunizations: Please check any immunizations you have had and note any reactions:

☐ Diphtheria, Pertussis, Tetanus, Polio, Hib _____
☐ MMR (measles, mumps, rubella) _____
☐ Influenza (flu shot) _____
☐ Hepatitis A and/or B _____
☐ HPV (Gardasil) _____
☐ Other _____

Lifestyle: Please report your utilization of the following and their frequency.

	Daily	**Weekly**
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____
Coffee/caffeine	_____	_____
Dairy products	_____	_____
Sweets	_____	_____
Meditation	_____	_____
Exercise	_____	_____

Family medical history: Please check areas pertaining to blood relatives NOT including yourself, and note whether the condition is from the maternal (M) or paternal (P) side of your family:

M	**P**		**M**	**P**		**M**	**P**	
❑	❑	Alcoholism	❑	❑	Epilepsy	❑	❑	Neurologic disorder
❑	❑	Asthma	❑	❑	Hay fever/allergies	❑	❑	Obesity
❑	❑	Anxiety	❑	❑	Heart disease/stroke	❑	❑	Substance abuse
❑	❑	Arthritis	❑	❑	Herpes	❑	❑	Thyroid problems
❑	❑	Cancer	❑	❑	High blood pressure	❑	❑	Diabetes

❑ ❑ Depression
❑ ❑ Eating disorder
❑ Other: Please list: _____
_____
_____
_____

❑ ❑ Liver disease
❑ ❑ Mental disorders

❑ ❑ Kidney disease

Please indicate the following conditions that pertain to you personally, including any significant past health concerns as well.

General
- ❑ Night sweats
- ❑ Fatigue
- ❑ Sleep disturbance
- ❑ Dizziness
- ❑ Stress
- ❑ Exposure to toxic chemicals

Skin
- ❑ Rashes/hives
- ❑ Infections/fungus/athlete's foot
- ❑ Dryness/scaling
- ❑ Hair/nail changes
- ❑ Moles/growth
- ❑ Other: _____

Head
- ❑ Headache/migraine
- ❑ Head injury
- ❑ Other:_____

Mouth and Throat
- ❑ Sore throat/hoarseness
- ❑ Mouth sores/gum problems
- ❑ Dental problems
- ❑ Silver/mercury filling(s)
- ❑ Root canal(s)
- ❑ Loss of sense of taste
- ❑ Other:_____

Nose/Sinuses
- ❑ Sinus problems/congestion
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Frequent colds
- ❑ Hay fever/rhinitis/congestions
- ❑ Other:_____

Eyes/Ears
- ❑ Recent change in vision
- ❑ Redness/itching of eyes
- ❑ Eye pain, tearing or dryness
- ❑ Loss of hearing
- ❑ Ringing in the ears
- ❑ Ear infection
- ❑ Other:_____

Respiratory
- ❑ Cough
- ❑ Difficult or painful breathing
- ❑ Shortness of breath
- ❑ Asthma
- ❑ Bronchitis
- ❑ Positive TB test
- ❑ Other:_____

Cardiovascular
- ❑ Angina, heart attack
- ❑ High blood pressure or stroke
- ❑ Murmurs
- ❑ Chest pain
- ❑ Ankle swelling
- ❑ Palpitations, fluttering, irregular beat
- ❑ Poor circulation
- ❑ Other:_____

Blood
- ❑ Anemia
- ❑ Easy bruising/bleeding
- ❑ Clots/thrombosis/DVT
- ❑ Other:_____

Endocrine
- ❑ Thyroid condition
- ❑ Heat or cold intolerance
- ❑ Blood sugar irregularities
- ❑ Easy weight gain
- ❑ Other:_____

Digestion
- ❑ Daily bowel movements
- ❑ Trouble swallowing
- ❑ Heartburn
- ❑ Abdominal pain
- ❑ History of parasites
- ❑ Change in thirst or appetite
- ❑ Nausea +/- vomiting
- ❑ Loose stools or diarrhea
- ❑ Constipation
- ❑ Blood or mucus in stools
- ❑ Diverticulitis
- ❑ Belching or gas/bloating
- ❑ Gall bladder disease
- ❑ Liver disease/jaundice

- ❑ Hemorrhoids
- ❑ History of eating disorder

Neurologic
- ❑ Fainting or seizures
- ❑ Numbness/tingling/paralysis
- ❑ Memory loss
- ❑ Other: _____

Emotional
- ❑ Depression
- ❑ Mood swings or mood disorder
- ❑ Anxiety/nervousness
- ❑ Other:_____

Musculoskeletal
- ❑ Joint pain or stiffness
- ❑ History of broken bone(s)
- ❑ Muscle spasms/cramps/weakness
- ❑ Neck/back pain
- ❑ Difficulty chewing, jaw clicking
- ❑ Other:_____

Urinary
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Frequency at night
- ❑ Inability to hold urine
- ❑ Bladder/kidney infection(s)
- ❑ Other:_____

Male
- ❑ Hernia/testicular mass or pain
- ❑ Self testicular exam regularly
- ❑ Sexual difficulties
- ❑ Prostate problems
- ❑ Sexually transmitted disease
- ❑ Discharge or sores
- ❑ Difficulty in stopping or starting urination
- ❑ Decreased flow or force of urination
- ❑ Other:_____

Female

Pregnant? Yes ❑ No ❑ Maybe ❑

Date of last pap: _____
- ❑ History of abnormal pap(s)
- ❑ Abnormal discharge
- ❑ Sexual difficulties
- ❑ Low libido
- ❑ History of sexually transmitted disease

Age menses began: _____

Number of pregnancies: _____ Births: _____

Number of miscarriages/abortions: _____
- ❑ *If menopausal, check here and skip the rest of this section*
- ❑ Regular cycles
- ❑ Bleeding between cycles
- ❑ Menstrual cramps
- ❑ Excess flow
- ❑ PMS
- ❑ Attempting conception
- ❑ Infertility

Date of last period: _____

Length of complete cycle (start of one period to start of the next):_____days

Days of flow: _____

Breast (male and female)
- ❑ Self exam regularly
- ❑ Lumps/pain or tenderness
- ❑ Discharge
- ❑ Other: _____