Adult Health Summary
East Gate Health
Dore Vanden Heuvel CTCMPAO #1063
348 Bagot St., #108, Kingston ON K7K 3B7
613.545.3598

Personal Information

First Name	Last Name
Telephone Home/Mobile Work	Email
Home/Street Address Apt # City Province Postal Code	Sex M F Other Marital Status
Date of Birth (DD/MM/YY)	Occupation

Emergency Contact Information

First Name	Last Name
Relationship to Patient	Phone

Family Doctor Name	Clinic Phone
Clinic Address	Clinic Email

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Ongoing Health Conditions
List any ongoing conditions.

Ongoing health conditions
Allergies to any drugs, foods, or chemicals
Drug reactions
Treatments that you have tried or are currently trying
Prescription medications
Over-the-counter medicines, vitamins, minerals, or homeopathic remedies

Past Medical History
List any relevant past medical history.

Hospitalizations
Surgeries
Prior injuries
Past medical conditions

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Review of Body Systems

Circle **C** if you currently have the problem and **P** if you had it in the past.

General					
Cancer _____	C	P	Sensitivity to cold	C	P
Excessive hair loss	C	P	Sudden tiredness/weakness	C	P
Fevers/chills	C	P	Time of day _____		
Sweat easily/excessively	C	P	Rapid weight gain/loss	C	P
Emotional/Mental					
Mood swings	C	P	Depression	C	P
Attempted suicide	C	P	Anxiety/nervousness	C	P
Tension	C	P	Poor concentration	C	P
Memory problems	C	P	Fears/phobias _____	C	P
Increased irritability	C	P	Mental mistakes	C	P
Easily angry	C	P	Hallucinations, hearing voices	C	P
Endocrine					
Hypothyroid	C	P	Sensitivity to cold	C	P
Hypoglycemia	C	P	Diabetes	C	P
Excessive thirst	C	P	Excessive hunger	C	P
Immune					
Reactions to vaccinations	C	P	Chronic infections	C	P
Chronic swollen glands	C	P	Chronic fatigue	C	P
Slow wound healing	C	P			
Skin					
Rashes	C	P	Psoriasis	C	P
Acne/boils	C	P	Dry skin	C	P
Hives	C	P	Eczema	C	P
Itching	C	P	New moles/changes in moles	C	P
Head					
Headaches	C	P	Migraines	C	P
Head injury	C	P	Jaw/TMJ problems	C	P
Dandruff	C	P	Sensitive scalp	C	P
Other _____					
Ears					
Hearing loss	C	P	Ringing	C	P
Earaches	C	P	Chronic ear infections	C	P
Discharge	C	P	Itching	C	P
Excess wax	C	P	Loss of balance/vertigo	C	P
Other _____					

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Eyes

Glasses/contacts	C	P	Since _____ ☐ Near sighted ☐ Far sighted		
Impaired vision	C	P	Eye pain/strain	C	P
Double vision	C	P	Cataracts	C	P
Spots in eyes	C	P	Tearing/dryness	C	P
Redness	C	P	Glaucoma	C	P
Sensitive to light	C	P	Discharge	C	P
Itching	C	P	Blurring	C	P
Blind spot(s)	C	P	Colour blind	C	P
Other _____					

Nose and Sinuses

Nose bleeds	C	P	Injury	C	P
Hay fever	C	P	Loss of smell	C	P
Stuffiness	C	P	Allergies	C	P
Sinus problems	C	P	Obstructions	C	P
Other _____					

Mouth and Throat

Frequent sore throat	C	P	Hoarseness	C	P
Grinding teeth	C	P	Bad breath	C	P
Jaw clicks	C	P	Metallic taste in mouth	C	P
Fever blisters	C	P	Canker sores	C	P
Gum problems	C	P	Sensitive teeth	C	P
Dental cavities	C	P	Loss of teeth	C	P
☐ Silver fillings ☐ Gold crowns			Other _____		

Neck

Lumps	C	P	Swollen glands	C	P
Goitre	C	P	Pain/stiffness	C	P
Other _____					

Neurological

Concussion/head injury	C	P	Paralysis	C	P
Muscle weakness	C	P	Numbness/tingling	C	P
Fainting	C	P	Loss of coordination	C	P
Loss of memory	C	P	Seizures/convulsions	C	P
Vertigo/dizziness	C	P	Loss of balance	C	P
Poor concentration	C	P	Speech problems	C	P
Other _____					

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Respiratory

Chronic or frequent cough	C	P	Frequent colds	C	P
Spitting up mucous	C	P	Spitting up blood	C	P
Wheezing	C	P	Chest pain	C	P
Pain on breathing	C	P	Difficulty breathing	C	P
Shortness of breath	C	P	Asthma	C	P
Bronchitis	C	P	Emphysema	C	P
Pneumonia	C	P	Pleurisy	C	P

Other _____

Cardiovascular

Palpitations/irregular heart beat	C	P	Heart disease	C	P
Stroke	C	P	Ankle/leg swelling	C	P
Rheumatic fever	C	P	Chest pain	C	P
Phlebitis	C	P	High/low blood pressure	C	P
Murmur	C	P	Easy bruising/bleeding	C	P

Other _____

Gastrointestinal

Difficulty swallowing	C	P	Heartburn	C	P
Bloating	C	P	Belching	C	P
Indigestion	C	P	Nausea/vomiting	C	P
Passing gas	C	P	Change in thirst	C	P
Change in appetite	C	P	Stomach pain	C	P
Ulcer	C	P	Spitting up blood	C	P
Diarrhea	C	P	Constipation	C	P
Colitis	C	P	Bloody stool	C	P
Hemorrhoids	C	P	Black stool	C	P
Hernia	C	P	Hepatitis	C	P
Rectal pain/itching	C	P	Change in bowel movement	C	P
Gall bladder issues	C	P	Bowel movements per day _____		

Food cravings _____ Foods that disagree _____

Urinary

Painful urination	C	P	Frequent urination during day/night	C	P
Strong smelling urine	C	P	Inability to hold urine	C	P
Inability to urinate	C	P	Swelling of hands/feet/ankles	C	P
Abnormal thirst	C	P	Kidney stones	C	P
Bladder/kidney disease/infections	C	P	Blood/sugar/pus in urine	C	P
Frequent infections	C	P	Colour of urine		
Decrease in flow	C	P	☐ Pale ☐ Yellow ☐ Dark ☐ Frothy		

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Reproductive

Herpes	C	P	Chlamydia	C	P
Gonorrhea	C	P	Syphilis	C	P
Genital infection	C	P	Warts on genitals	C	P
HIV+	☐ Yes	☐ No			
Sexually active now	☐ Yes	☐ No	Other _____		
Pain during intercourse	☐ Yes	☐ No			

Male

Hernias	C	P	Frequent masturbation	C	P
Testicular pain	C	P	Difficult or loss of erection	C	P
Painful erection	C	P	Lump/swelling/mass in testicles	C	P
Infertility	C	P	Prostate disease	C	P
Discharge or sores	C	P			

Female

Menopause ☐ Yes ☐ No

If yes, age of last menses _____ Symptoms of menopause

_____

Age of first menses _____

Length of cycle ____ days

Duration of flow _____ days

☐ Clots ☐ Light ☐ Medium ☐ Heavy

Regular cycle ☐ Yes ☐ No

Bleeding between cycles ☐ Yes ☐ No

Pain or cramps ☐ Yes ☐ No

☐ Before flow ☐ After flow starts

Abnormal PAP	C	P	Vaginal infections/discharge	C	P
Vaginal dryness	C	P	Vaginal itchiness	C	P
Swelling/lumps in breasts	C	P	Nipple discharges	C	P
Ovarian cysts	C	P	Cervical dysplasia	C	P
Endometriosis	C	P	Uterine fibroids	C	P

Type of birth control _____

Number of pregnancies _____

Number of miscarriages _____

Difficulty conceiving ☐ Yes ☐ No

Number of live births _____

Number of abortions _____

Check all PMS symptoms that apply.

☐ Depression ☐ Bloating ☐ Increased appetite ☐ Weight gain ☐ Breast tenderness

☐ Other _____

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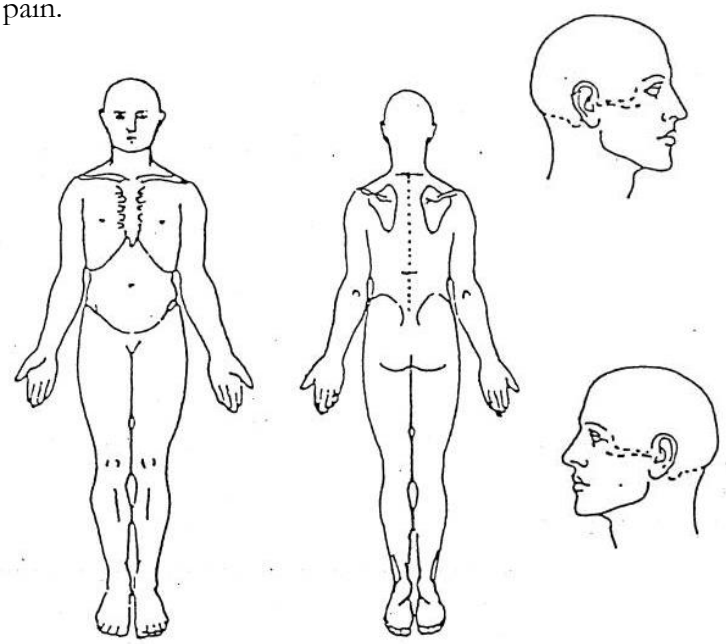
Musculoskeletal					
Joint pain or stiffness	C	P	Arthritis/rheumatism	C	P
Broken bones	C	P	Numbness/tingling	C	P
Muscle spasms/cramps	C	P	Weakness	C	P
Back pain	C	P	Shoulder pain	C	P
Other _____					

Pain

Use the diagrams to show where you have pain.



Describe the pain.

_____

_____

How intense is the pain?.

_____

_____

How often do you have the pain?

_____

What helps to reduce the pain? _____

What makes the pain worse? _____

Signature of Patient _____ or Decision Maker _____

Date _____ Relationship to patient _____

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