Family Naturopathic Clinic
Mark Orbay, B.Sc., N.D. Doctor of Naturopathic Medicine
265 Carling Avenue, Suite 610
Tel: (613) 230-6100 Fax: (613) 230-0070

Name:_____ Phone (Home)_____
Address:_____ (Office) _____
Date of Birth:_____/_____/_____ Age: _____
(Month) (Day) (Year) Birth Place: _____
Marital Status:_____
Occupation: _____ Name of spouse:_____

Name of family Medical Doctor:_____

Who referred you to the clinic?_____

Present weight:_____
Normal weight:_____
When were you last this weight?_____
What is your chief concern about your health? _____
_____
_____
_____
If this is a chronic condition, how long have you had this condition?_____
Who diagnosed your illness?_____
When was the diagnosis made? _____
What specialists have you seen? (Please also indicate year of consultation)_____
_____
How has your condition(s) been treated until now?_____
_____
What else would you like to see changed in your health? (Indicate how long you have had each of these conditions.)
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7._____
8. _____
9._____
10._____

How long has it been since you have been totally well? _____

Previous History:

Measles_____ Gallstones _____ Bowel Disease _____
Mumps _____ High Blood Pressure_____ Rashes _____
Scarlet Fever _____ Pleurisy _____ Malaria _____
Whooping Cough____ Arthritis_____ Gonorrhea _____
Croup _____ Rheumatism _____ Chlamydia _____
Pneumonia _____ Gout _____ Asthma _____
Tuberculosis_____ Genital Herpes _____ Constipation _____
Mononucleosis_____ Hay fever _____ Diphtheria _____
Ear infections_____ Chicken pox _____ Candida _____
Depression _____ Allergies _____ Hypoglycemia_____
Sinusitis _____ Colds and Flus _____ Swollen glands _____
Eczema _____ Cancer _____ Parasites _____
Diabetes _____ Kidney conditions _____ Hypothyroidism_____
Hyperthyroidism____ Angina _____ Shingles _____
Stroke_____ TMJ Dysfunction _____ Urinary Tract Infection_____
Alcoholism _____ Anemia_____ Back and Neck Pain_____
Chronic fatigue_____ Fibromyalgia_____ Dental Disorders_____
Meningitis _____ Jaundice _____
Digestive disorders_____ Crohn's Disease_____
Stomach ulcer _____ Celiac's disease _____
Insomnia _____ Varicose Veins _____
Ringing in ears/Tinnitus _____ Trauma _____
Environmental Illness_____ Eye Disorders_____
Headaches _____ Hemorrhoids _____
Hepatitis _____ Infertility _____
Learning Disorders _____ Lyme's disease _____
Obesity _____ Osteoporosis_____
Other _____

Were any of the above severe? If so give age, severity, and duration.

_____
_____
_____

Do you donate blood on a regular basis? Yes _____ No _____
Have you donated blood in the past? Yes___ No _____

Infectious Disease Status:

Did you receive a blood transfusion in Canada between 1980 and 1990? Yes_____ No_____
Do you have hepatitis A, B, or C? Yes _____If yes, which one(s)?_____No _____
Are you HIV positive or do you have AIDS? Yes___ No___
Are you in close contact with an infected person who has one of the above diseases? Yes _____ No____
List any other infectious diseases that you have _____

Describe your general state of health as a child _____
_____
_____
_____

Describe your general state of health as a teenager _____
_____
_____

Surgeries: Please indicate the type of surgery, date, and where it was performed.
_____
_____

Accidents: Please indicate the injuries sustained, severity, when they occurred, and any necessary treatments_____
_____

Family History: Please indicate the age of all your immediate family members living (L = living) and indicate the age at which any member became deceased (D = deceased)

Father	L _____	D _____	Mother	L _____	D _____
Brothers	L _____	D _____	Sisters	L _____	D _____
	L _____	D _____		L _____	D _____
	L _____	D _____		L _____	D _____

Indicate the number of relatives: grandparents, parents, brothers, or sisters who have or had the following diseases.

Diabetes _____	Cancer _____	Heart Disease_____
Mental Illness _____	Alzheimer's Disease _____	Tuberculosis _____
Arthritis _____	High Blood Pressure _____	Allergies _____
Kidney Disease_____	Stomach Disorders_____	

Additional Male History:

Have you ever had any prostate problems? Yes ____ No _____
If yes, please describe. _____

Have you ever experienced any bladder problems? Yes ____ No __

Please list any other male conditions you have:_____
_____
_____
_____
_____

Additional Female History

Age of first period/menses_____ Age of cessation of menses _____
Are your menses regular? _____ Irregular? _____
Do you experience PMS symptoms? Yes ___ No ___
If yes, what do you experience? _____
_____
_____
Have you experienced fibrocystic disease of the breast? Yes _____ No _____
Have you ever had uterine fibroids? Yes ___ No __
Do you have recurring vaginal infections? Never _____ Rarely _____
Frequently _____ More than three times a year _____

Number of Children _____ Ages: _____
Number of pregnancies _____ Deliveries _____
Miscarriages _____ Abortions _____
Were there any complications associated with the above? _____
_____
_____

Please list any other female conditions that you have_____
_____
_____

Medications:

List all the prescribed medications you are currently taking. Indicate the drug name, dosage, frequency, and how long you have been taking it.

1. _____
2. _____
3. _____
4. _____
5. _____

List all prescribed medications that you have taken in the past for any period of time longer than three months.

1. _____
2. _____
3. _____
4. _____
5. _____

List any prescribed medications that you have had a bad reaction to in the past. Indicate the drug name, when you took it, and the adverse reaction you had.

1. _____
2. _____
3. _____

How many courses of antibiotics have you had in the past ten years?
Have you had a bad reaction to any antibiotics? Yes _____ No _____

List any over-the-counter medications you take (i.e. Aspirin, Tylenol, Tums)
Indicate whether you take them rarely, occasionally, frequently, or daily.
1. _____
2. _____
3. _____

Have you ever used recreational drugs? Yes _____ No _____
Do you currently use recreational drugs? Yes _____ No _____
(If yes, indicate type and frequency of usage). _____
_____
_____

Have you ever had a severe reaction from a vaccination? Yes _____ No _____
(If yes, explain vaccination type, when it was administered, and the reaction).
_____
_____
_____

List all food supplements you are presently taking. Indicate the total dosage taken daily
(i.e. If you take 2 tablets of vitamin C 500 mg/day, the total is 1000mg.)
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Lifestyle:

How many cups/bottles/glasses do you drink of the following on an average day?
Coffee _____ Tea _____ Water _____ Milk (2%) _____
Milk (skim) _____ Fruit Juice _____ Soft Drinks (regular) _____
Soft Drinks (diet) ____ Vegetable Juices ____ Herbal Tea _____
Beer _____ Wine _____ Liquor_____
How often would you have an alcoholic beverage per week?_____

Do you smoke? Yes _____(How many cigarettes/day?_____Cigars/day?___) No __
Have you ever smoked? _____ For how long? _____
Does anyone else smoke in the household? Yes ____ No _____
Does anyone smoke in your workplace? Yes_____ No_____

List any work-related or household environmental concerns and hazards_____
_____
_____
_____

How many hours do you work each week? _____

What do you do for exercise? (Indicate type of exercise, and frequency per week)
_____
_____
_____

What do you do for recreation? _____
What are your hobbies? _____

How many hours per day do you watch television and surf the Internet? _____

What, if any, pets do you have? _____

How many hours of sleep do you get on average? _____

When was your last vacation? How long was it? _____

What level of personal stress (rated as a percentage) are you currently experiencing in each of the following areas?
Financial_____ Job related_____ Interpersonal_____
Marriage _____ Health _____ Family members_____
Spiritual_____ Unfulfilled expectations____ Other _____

Do you participate in any religious group? Are you an active participant?
_____
_____

Thank you for taking the time to fill out the requested information. It will help greatly in our study of your present health concerns and will assist us in choosing an appropriate direction for your restoration of health.