DR. B. GLUVIC AND DR. T. DUONG
VILLAGE HEALTH CLINIC – Naturopathic Medical & Midwifery Care

ADULT HISTORY

(CONFIDENTIAL: All information in this form remains confidential and will be released only on your written permission)

FULL NAME _____ BIRTHDATE month/day/yr _____/_____/_____ AGE _____

NAME YOU PREFER TO BE CALLED _____ SEX _____ SINGLE / MARRIED / COMMON-LAW / DIVORCED

ADDRESS _____ CITY _____ POSTAL CODE _____

OCCUPATION _____ EMPLOYER _____

PHONE: CELL _____ HOME _____WORK_____ EMAIL ADDRESS_____

FAMILY PHYSICIAN _____ CHIROPRACTOR_____ SPECIALIST _____

WHO REFERRED YOU TO AND/OR HOW DID YOU LEARN OF THIS OFFICE? _____

PRESENT HEALTH PROBLEMS: LIST YOUR MAIN HEALTH CONCERNS / SYMPTOMS

1) _____ WHAT TREATMENTS HAVE BEEN TRIED ? _____

2) _____ _____

MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING ? (CIRCLE)

ANEMIA	RHEUMATIC FEVER	HEART ATTACK
HEPATITIS/LIVER DISEASE	KIDNEY STONES	HIGH BLOOD PRESSURE
HAYFEVER	ASTHMA	PNEUMONIA
TUBERCULOSIS	CANCER OF_____	BLADDER/VAGINAL INFEC.
STOMACH ULCER	MIGRAINE HEADACHES	ABNORMAL PAP TEST
MEASLES	MUMPS	PROSTATE PROBLEMS
COLITIS	ARTHRITIS/RHEUMATISM	BLEEDING TENDENCIES
BLOOD CLOTS	HIVES	MONONUCLEOSIS
GALLBLADDER PROBLEMS	THYROID PROBLEMS	SEXUALLY TRANSMITTED
ANGINA/CHEST PAIN	HEART DISEASE	DISEASE
POLIO	DIABETES	ECZEMA
STROKE	ALCOHOL/DRUG ABUSE	DEPRESSION
EPILEPSY	MENTAL DISORDER	EATING DISORDER
SMOKER? (Y OR N)		

SURGERIES (YEAR & TYPE) _____

_____

_____

HOSPITALIZATIONS (YEAR & REASON) _____

_____

_____

INJURIES/ACCIDENTS (YEAR & CAUSE) _____

_____

OTHER CONDITIONS _____

FATHER (age)* _____ BROTHERS (ages)* _____

MOTHER (age)* _____ SISTERS (ages)* _____

* If deceased, Please list age at death and circle.

HAVE ANY OF THE ABOVE HAD THE FOLLOWING ? (CIRCLE)

DIABETES	KIDNEY DISEASE	STOMACH ULCERS
HEART DISEASE	ASTHMA	HIGH BLOOD PRESSURE
ALLERGIES	ARTHRITIS	NERVOUS BREAKDOWN
GOUT	COLITIS	BLEEDING TENDENCIES
ALCOHOLISM	TUBERCULOSIS	PSYCHIATRIC ILLNESS
CANCER	STROKE	GALLBLADDER PROBLEM

NUMBER OF CHILDREN _____ AGES _____

NUMBER OF PREGNANCIES _____ DELIVERIES_____

MISCARRIAGES _____ ACCIDENTAL _____ INDUCED_____

COMPLICATIONS _____

BIRTH CONTROL METHODS: IN PAST _____

NOW _____

ARE YOU PREGNANT AT THIS TIME ? _____

KNOWN ALLERGIES (include medicines, pollens, animals, foods & chemicals): _____

_____

CURRENT MEDICATIONS (list all prescription & over the counter medicines, **vitamins, minerals, herbs** that you take):

_____

_____

_____

ANY MISSED / RESCHEDULED APPOINTMENTS WITH LESS THAN 48 HOURS NOTICE WILL RESULT IN A CHARGE FOR THE FULL COST OF THE MISSED APPOINTMENT. PAYMENT FOR SERVICES, IE. CONSULTATIONS, LAB PROCEDURES AND MEDICAL THERAPY, IS DUE AT THE TIME SERVICE IS RENDERE

I UNDERSTAND THE TERMS AND CONDITIONS AS STATED ABOVE. ***SIGNATURE:*** _____

MEAL (Indicate breakfast, lunch, dinner, or snack)	TIME	FOOD DESCRIPTION AND QUANTITY (for example: 1 cup oatmeal, 1 apple, 1 glass of 2% milk)	BEVERAGES (water, juice, pop, coffee, tea,…) and Quantity (1 cup)