DOCTOR DHILLON
NATUROPATHIC PHYSICIAN

Patient Information

Date _____

First name | Last name

Middle name(s) | I go by

Care Card/Services Card number (PHN)

Birthdate (yy/mm/dd) | Age | Please circle: Male Female Other

Home address

City | Postal Code

Home telephone | Cellphone

Email (We will not share, rent or sell your email address.)

I would like to be reminded of my upcoming appointments by… ☐ Email ☐ Text ☐ Both Email and Text

I would like to receive Dr. Vinnie Dhillon, ND Naturopathic Physician's free email newsletter featuring clinic news and health and wellness information. ☐ Yes ☐ No (You may unsubscribe at any time.)

Occupation | Business/employer

Do you have an extended health plan? ☐ Yes ☐ No

Extended Benefits Policy/Group # | Extended Benefits Member ID #

Name of current General Practitioner (MD)

Date of last visit to GP | Reason for last visit

Emergency Contact | Telephone

Confidential Health Information

What is the reason for your visit today? (Please describe in detail)

Please list relevant past medical issues:

Are you seeing a Medical Specialist? ☐ Yes ☐ No

Reason for seeing Specialist:

Do you have any recent Imaging Reports? ☐ Yes ☐ No

Do you have any recent Blood Work Reports? ☐ Yes ☐ No

Medications / Supplements

Please check if you take or use any of the following:

☐ Antacids ☐ Anti-Inflammatory ☐ Caffeine ☐ Laxatives ☐ Sleeping Pills

☐ Cannabis ☐ Pain Relievers ☐ Cortisone ☐ Tranquilizers

Please list any other Medications (prescriptions or over the counter) that you are taking, as well as your reasons for taking them:

Please list ay Supplements (multi-vitamin, gingko, etc.) that you are taking, as well as your reasons for taking them:

Were you ever on antibiotics for more than 1 month over the last 10 years?

Have you ever used probiotics (acidophilus) following antibiotic use? ☐ Yes ☐ No

Surgeries / Hospitalizations

Please list any previous surgeries or hospitalizations, as well as the date:

Overall Stress Level (Please Rate) ☐ None ☐ Low ☐ Medium ☐ High

Please provide the main reason(s) for your stress:

Exercise

How often do you exercise? (Please describe your exercise)

Substance Use History

Do you currently Smoke? ☐ Yes ☐ No How much? per day For how long? years

Please select if any of the following apply to you: ☐ Alcohol ☐ Vaping ☐ Cannabis ☐ Other Substance

Other

Are you Pregnant? ☐ Yes ☐ No ☐ Maybe

If applicable, what is your due date?

Do you have children? ☐ Yes ☐ No

Menstrual Cycle: ☐ Regular ☐ Irregular ☐ Cramps ☐ Painful Cycle

Are you Menopausal or Perimenopausal? Yes No ☐ Not ☐ sure ☐

When was your last annual Pap/Breast exam:

Immunizations

Did you receive general childhood vaccinations? ☐ Yes ☐ No

Please list any vaccinations you have had:

Allergies

Please list any allergies or hypersensitivities to any medications:

Please list any allergies or hypersensitivities to any foods:

Please list any environmental and/or chemical allergies or hypersensitivities:

Family History

Please check any of the following, which are applicable to your family history:

☐ I don't know my family history ☐ Arthritis ☐ Asthma/Allergies ☐ Cancer ☐ Depression
☐ Drug/Alcohol abuse ☐ Epilepsy ☐ High blood pressure ☐ Stroke
☐ Kidney disease ☐ Diabetes ☐ High cholesterol ☐ Mental illness

Please list any other family history that may be relevant:

Sleep

Time you retire:

Time you wake up:

Do you have problems falling asleep? ☐ Yes ☐ No

Do you have problems staying asleep? ☐ Yes ☐ No

Do you wake rested in the morning? ☐ Yes ☐ No

Diet

Do you follow any particular diet regimens or restrictions? ☐ Yes ☐ No

If applicable, please describe any particular diet regiments or restrictions:

Describe Your Daily Dietary Intake…

Breakfast:

Lunch:

Dinner:

Snacks:

Fluids:

Review of Systems
(Please check the appropriate box for any of the following symptoms)

General
- ☐ Insomnia
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain

Head
- ☐ Headaches
- ☐ Dizziness
- ☐ Head trauma
- ☐ Fainting
- ☐ Blacking out

Eyes
- ☐ Itching/redness
- ☐ Change in vision
- ☐ Cataracts
- ☐ Light sensitivity
- ☐ Spots in vision
- ☐ Glaucoma

Ears
- ☐ Impaired hearing
- ☐ Earache
- ☐ Dizziness
- ☐ Discharge
- ☐ Ringing/tinnitus

Mouth & Throat
- ☐ Bleeding gums
- ☐ Cold sores
- ☐ Sore throat
- ☐ Jaw/TMJ problems
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Goiter

Nose
- ☐ Hayfever
- ☐ Loss of smell
- ☐ Nosebleeds
- ☐ Sinus problems

Lungs
- ☐ Difficult breathing
- ☐ Shortness of breath
- ☐ Persistent breath
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Infections

Vascular
- ☐ Angina
- ☐ Murmurs
- ☐ Heart disease
- ☐ Chest pain
- ☐ Palpitations
- ☐ Ankle swelling
- ☐ Cold feet/hands
- ☐ Leg cramps
- ☐ Calf pain
- ☐ Varicose veins
- ☐ Low blood pressure
- ☐ High blood pressure

Gastro-Intestinal
- ☐ Bloating/gas
- ☐ Heartburn
- ☐ Ulcers
- ☐ Liver disease
- ☐ Gall bladder disease
- ☐ Vomiting/nausea
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Hernias

__ number of bowel movements per day

Gastro-Urinary
- ☐ Difficulty urinating
- ☐ Pain urinating
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Bed-wetting
- ☐ Urinary urgency
- ☐ Frequent urination
- ☐ Frequent infections
- ☐ Kidney stones

Neurological
- ☐ Seizures/epilepsy
- ☐ Strokes
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle weakness
- ☐ Difficult walking
- ☐ Poor coordination
- ☐ Paralysis
- ☐ Speech problems
- ☐ Loss of memory

Muscle & Bone
- ☐ Joint pain
- ☐ Swollen joints
- ☐ Stiffness
- ☐ Muscle ache
- ☐ Foot trouble
- ☐ Arthritis
- ☐ Bone pain
- ☐ Fractures
- ☐ Dislocations

Skin
- ☐ Rash
- ☐ Itching/hives
- ☐ Changes in moles
- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema

Endocrine
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hormone therapy
- ☐ Thyroid problems
- ☐ Heat/cold intolerance
- ☐ Excessive thirst/hunger
- ☐ Excessive sweating
- ☐ Night sweats

Emotional
- ☐ Depression mood swings
- ☐ Anxiety/nervousness
- ☐ Tension
- ☐ Phobias
- ☐ Alcohol/drug abuse

Conditions
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Cancer/tumor
- ☐ Chronic fatigue
- ☐ Eating disorder
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Headache unlike any experienced
- ☐ Heart condition
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Polio
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ TIAs (Transient Ischemic Attacks)