

Dr. Nadine Cyr B.A., N.D.
Doctor of Naturopathic Medicine

Name: _____ Age: _____ Date of Birth: _____

Address: _____

(Street)

(City)

(Postal Code)

Occupation: _____ Employer: _____

Home Phone: _____ Work Phone: _____

e-mail: _____ Cell: _____

Marital Status: S M D W Sep

Referred by: _____

Health Concerns in Order of Importance to You:

- 1) _____ since: _____ prior treatment: _____
- 2) _____ since: _____ prior treatment: _____
- 3) _____ since: _____ prior treatment: _____
- 4) _____ since: _____ prior treatment: _____

Current Treatments/Medications:

- 1) _____ since: _____ adverse reactions: _____
- 2) _____ since: _____ adverse reactions: _____
- 3) _____ since: _____ adverse reactions: _____

Which of the Following Conditions Have You Experienced?

Abcesses	Depression	Heart Disease	Mononucleosis	Rubella	Stroke
Alcoholism	Diabetes	Hepatitis	Mumps	Scarlet Fever	Hives
Allergies	Emphysema	Herpes	Parasites	Sexual Abuse	Tonsilitis
Anemia	Epilepsy	Influenza	Cervical dysplasia	Chronic Fatigue	Thyroid Disorders
Arthritis	Gall Stones	Kidney Stones	PCO's	Strep Throat	Tuberculosis
Asthma	Goitre	Bronchitis	Hemorrhage	Sinusitis	Venereal Disease
Cancer	Colitis	Malaria	Pneumonia	Sunstroke	Warts
Chicken Pox	Gout	Measles	Prostatitis	Fainting	Whooping Cough
Cold Sores	Hay Fever	Miscarriage	Psoriasis	Eczema	Hypertension
Shingles	Diarrhea	Constipation	Insomnia	Migraine Headaches	Anxiety
Infertility	Aneurism	Low Blood Pressure		Blood transfusions	Chronic infection
Spinal Injury	Ulcer	Bladder/Kidney Infection		Canker Sores	Cavities

Family history

Please indicate which of the following ailments have affected your relatives:

- | | | | | |
|------------|----------|--------------|---------------|-----------------------------|
| Alcoholism | Asthma | Diabetes | Anxiety | Tuberculosis |
| Allergies | Cancer | Depression | Heart Disease | Ulcerative Colitis/ Crohn's |
| Arthritis | Epilepsy | Fibromyalgia | Osteoporosis | Thyroid Disorders |

Relative	Age if alive	Age at death	Ailments
Mother:	_____	_____	_____
Father:	_____	_____	_____
Brothers:	_____	_____	_____
Sisters:	_____	_____	_____
Children:	_____	_____	_____

Past Injuries

- 1) _____ when: _____ complications: _____
- 2) _____ when: _____ complications: _____
- 3) _____ when: _____ complications: _____

Past Surgeries

- 1) _____ since: _____ complications: _____
- 2) _____ since: _____ complications: _____
- 3) _____ since: _____ complications: _____

Past Vaccinations: _____
 Adverse Reactions: _____

Prolonged Antibiotic Use? _____ When? _____
 For which condition(s)? _____

What exercise do you do and how much? _____

How much of the following substances are you using?

Coffee: _____ Tea: _____ Alcohol: _____
 Soda/Pop: _____ Tobacco: _____ Recreational Drugs: _____