

Zeynep Uraz, B.Sc., N.D.

Mahaya Health Services, 2 College Street, Suite 105
Toronto, ON M5G 1K3 T: 647.435.0152

PATIENT INFORMATION FORM

Date of initial visit:		
PATIENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Street Address:		City:
Postal Code:	Home phone number:	Daytime phone number:
May we leave messages relating to your visits: <input type="checkbox"/> Yes <input type="checkbox"/> No		Email:
Date of Birth: (MM/DD/YYYY)	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	
EMERGENCY CONTACT INFORMATION		
1. Last Name:	First Name:	Relationship:
Daytime phone number:		Evening phone number:
2. Last Name:	First Name:	Relationship:
Daytime phone number:		Evening phone number:
OTHER HEALTH CARE PROVIDERS		
1. Name: Phone number: Specialty/focus:	2. Name: Phone number: Specialty/focus:	3. Name: Phone number: Specialty/focus:
Date of last visit to medical doctor: Are you currently under his/her care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please list regular screening tests done by other physicians (blood tests, physical screening tests):	

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Health concerns in order of importance to you: 1.
2.
3.
4.
5.
6.

ALTH HISTORY QUESTIONNAIRE	
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.	
Date of last physical exam:	Have you been to a Naturopathic Doctor before? <input type="checkbox"/> Yes <input type="checkbox"/> No
Immunizations: <input type="checkbox"/> Tetanus <input type="checkbox"/> Smallpox <input type="checkbox"/> DPT <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Chickenpox <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Influenza (flu shot) <input type="checkbox"/> MMR	
List if any of these caused adverse reactions:	
Childhood illnesses: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
List any medical conditions that other doctors have diagnosed: 1.	
2.	
3.	
4.	
5.	
Surgeries:	

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Year	Type of Surgery	Reason

Other Hospitalizations:

Year	Reason

List your prescribed drugs, over-the-counter medications and supplements, (pain killers, vitamins, herbs, homeopathics, etc...)

Medication	Dosage/day	Date started

Have you ever had a blood transfusion? Yes No

Please list all allergies (medications, foods, supplements, environmental, etc...)

Name of allergen:	Reaction you had:

HEALTH HABITS AND PERSONAL SAFETY

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Exercise	<input type="checkbox"/> Sedentary (No exercise)	
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)	
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation at least 3x/week for 30 minutes)	
Diet	Are you dieting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?	
	Dietary restrictions? (Religious, vegetarian, vegan?)	
	Rank salt intake	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
	Rank carbohydrate intake	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola	
	# of cups/cans per day?	

Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per week?	
Tobacco	Are you exposed to second hand smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Other (add amount)
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit
Drugs	Do you currently use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:	
	Any discomfort with intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY

INCLUDING: ALLERGIES, ASTHMA, HEART DISEASE, HIGH BLOOD PRESSURE, CANCER, DIABETES, DEPRESSION, OTHER MENTAL ILLNESS, DRUG ABUSE, ALCOHOLISM, KIDNEY DISEASE AND ANY OTHER RELEVANT HEALTH PROBLEMS.

	AGE	SIGNIFICANT HEALTH PROBLEMS			AGE	SIGNIFICANT HEALTH PROBLEMS	
FATHER				CHILDREN		<input type="checkbox"/> M <input type="checkbox"/> F	
MOTHER						<input type="checkbox"/> M <input type="checkbox"/> F	
SIBLINGS		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F	
		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F	
GRANDMOTHER (maternal)				GRANDMOTHER (paternal)			
GRANDFATHER (maternal)				GRANDFATHER (paternal)			

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I don't know my family history

SYSTEMS REVIEW

Beside each item, please circle Y (Yes), N (No), or P (Past). Please write any information required in the space provided.

SKIN

Rashes	Y N P	
Eczema	Y N P	
Hives	Y N P	
Acne or boils	Y N P	
Itching	Y N P	
Colour change	Y N P	
Lumps	Y N P	
Dryness	Y N P	
Moistness	Y N P	
Nail changes	Y N P	
Changes in mole(s)	Y N P	
Skin cancer	Y N P	
Night sweats	Y N P	
Other		

HEAD

Headache	Y N P	
Head injury	Y N P	
Other		

EYES

Impaired vision	Y N P	
Eye pain	Y N P	
Tearing	Y N P	
Dryness	Y N P	
Double vision	Y N P	
Glaucoma	Y N P	
Cataracts	Y N P	
Blurring	Y N P	
Bothered by sun	Y N P	
Itching	Y N P	
Redness	Y N P	

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Discharge	Y N P	
Blind spot	Y N P	
Other		
EARS		
Impaired hearing	Y N P	
Earache	Y N P	
Dizziness	Y N P	
Discharge	Y N P	
Infections	Y N P	
Other		
NOSE AND SINUSES		
Frequent colds	Y N P	
Nose bleeds	Y N P	
Stuffiness	Y N P	
Hayfever	Y N P	
Sinus problems	Y N P	
Other		
MOUTH AND THROAT		
Frequent sore throat	Y N P	
Sore tongue or mouth	Y N P	
Gum problems	Y N P	
Hoarseness	Y N P	
Dental cavities	Y N P	
Loss of taste	Y N P	
Sores in and around the mouth	Y N P	
Other		
NECK		
Lumps	Y N P	
Swollen glands	Y N P	
Goiter	Y N P	
Pain or stiffness	Y N P	
Other		
RESPIRATORY		
Cough	Y N P	

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Sputum/phlegm	Y N P	
Wheezing	Y N P	
Asthma	Y N P	
Bronchitis	Y N P	
Pneumonia	Y N P	
Emphysema	Y N P	
Difficulty breathing	Y N P	
Pain on breathing	Y N P	
Shortness of breath	Y N P	
Tuberculosis	Y N P	
Last tuberculin test		
Last chest xray		
Other		
CARDIOVASCULAR		
Heart disease	Y N P	
Angina	Y N P	
High blood pressure	Y N P	
Murmurs	Y N P	
Rheumatic fever	Y N P	
Chest pain	Y N P	
Swelling in ankles	Y N P	
Palpitations/fluttering	Y N P	
Cyanosis	Y N P	
Other		
Past ECG		
Other heart tests		
BREAST		
Lumps	Y N P	
Pain or tenderness	Y N P	
Nipple discharge	Y N P	
Do you do self-breast exams?		
Gastrointestinal		
Trouble swallowing	Y N P	
Heartburn	Y N P	

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Change in thirst	Y N P	
Change in appetite	Y N P	
Nausea	Y N P	
Vomiting	Y N P	
Vomiting blood	Y N P	
Blood in stool	Y N P	
Belching or passing gas	Y N P	
Liver disease	Y N P	
Gallbladder disease	Y N P	
Jaundice (yellow skin)	Y N P	
Ulcer	Y N P	
Indigestion	Y N P	
Diarrhea	Y N P	
Rectal bleeding	Y N P	
Hemorrhoids	Y N P	
Black tarry stool	Y N P	
Light grey stool	Y N P	
Hernias	Y N P	
Bowel movements (how often?)		
Is this a change?		
Other		
URINARY		
Pain on urination	Y N P	
Increased frequency	Y N P	
Frequency at night	Y N P	
Inability to hold urine	Y N P	
Frequent urinary infections	Y N P	
Kidney stones	Y N P	
Blood in urine	Y N P	
Urgency	Y N P	
Hesitancy	Y N P	
Other		
MUSCULOSKELETAL		
Joint pain or stiffness	Y N P	
Arthritis	Y N P	

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Broken bones	Y N P	
Muscle spasms or cramps	Y N P	
Weakness	Y N P	
Joint swelling	Y N P	
Backache	Y N P	
Other		
PERIPHERAL VASCULAR		
Deep leg pain	Y N P	
Cold hands and feet	Y N P	
Varicose veins	Y N P	
Thrombophlebitis	Y N P	
Leg cramps	Y N P	
Extremity numbness	Y N P	
Extremity swelling	Y N P	
Extremity ulcers	Y N P	
Other		
NEUROLOGICAL		
Dizziness	Y N P	
Fainting	Y N P	
Seizures/convulsions	Y N P	
Paralysis	Y N P	
Muscle weakness	Y N P	
Numbness or tingling	Y N P	
Loss of memory	Y N P	
Involuntary movement	Y N P	
Loss of balance	Y N P	
Speech problems	Y N P	
Other		
ENDOCRINE		
Excessive thirst	Y N P	
Excessive urination	Y N P	
Excessive sweating	Y N P	
Excessive hair growth	Y N P	
Other		

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BLOOD AND LYMPHATICS		
Anemia	Y N P	
Easy bleeding or bruising	Y N P	
Lymph node swelling	Y N P	
Other		
EMOTIONAL		
Depression	Y N P	
Mania	Y N P	
Mood swings	Y N P	
Anxiety and nervousness	Y N P	
Phobias	Y N P	
Insomnia	Y N P	
Other		
HOBBIES AND HABITS		
Do you eat three meals a day?	Y N P	
Do you sleep well?	Y N P	
Do you average 8 hours sleep a night?	Y N P	
Do you enjoy your work?	Y N P	
Do you watch television?	Y N P	
If yes, how many hours do you watch?		
Do you take vacations?	Y N P	
What are your hobbies?		
FEMALE		
Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	Y N P	
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	Y N P	
Have you had a D&C, hysterectomy, or Cesarean?	Y N P	
Any urinary tract, bladder, or kidney infections within the last year?	Y N P	
Any blood in your urine?	Y N P	
Any problems with control of urination?	Y N P	
Any hot flashes or sweating at night?	Y N P	

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Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	Y N P	
Experienced any recent breast tenderness, lumps, or nipple discharge?	Y N P	
Date of last pap?		
MALE		
Do you usually get up to urinate during the night?	Y N P	
If yes, # of times _____	Y N P	
Do you feel pain or burning with urination?	Y N P	
Any blood in your urine?	Y N P	
Do you feel burning discharge from penis?	Y N P	
Has the force of your urination decreased?	Y N P	
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Y N P	
Do you have any problems emptying your bladder completely?	Y N P	
Any difficulty with erection or ejaculation?	Y N P	
Any testicle pain or swelling?	Y N P	
Date of last prostate and rectal exam?		