

ADULT HISTORY

Date: _____

**ONTARIO
COLLEGE OF
HOMEOPATHIC
MEDICINE**



Name:				
Address:				
City:		Province:		Postal Code:
Home Phone:		Cel. Phone:		Work Phone:
E-mail address: <i>Would you like to be added to our mailing list to receive special offers and event notices? Yes No</i>				
Marital Status:		Single	Married	Divorced Widowed
Date of Birth:		Age:	Sex: M	F
Weight:		Height:		
Number of Children, if any:			Occupation:	
For female patients only:		Number of Pregnancies:		Age at first menses:
Emergency Contact Name:			Phone:	
Family physician (name and tel No.): How did you hear about OCHM Student Clinic?				
<i>Referral: Newspaper: Public Health Talk: Internet/Website: Other:</i>				
<i>What are your main concerns in order of priority? Since when?</i>				
<i>Are you currently taking any medications or supplements? For how long?</i>				
<i>Can you trace the origin of your illness to any particular circumstance, accident, illness, incident or mental upset? (e.g., shock, worry, dietary, overexertion, weather)?</i>				

Please check which of the following substances you are currently using:

Alcohol	How much? _____	Pain Killers	How much? _____
Chewing Tobacco	How much? _____	Recreational Drugs	How much? _____
Cigarettes	How much? _____	Sleeping Pills	How much? _____
Coffee	How much? _____	Supplements/Herbs	How much? _____
Laxatives/Purgatives	How much? _____	Tea	How much? _____

Please check which of the following you have experienced or are suffering from now:

Abortion	Diabetes	Hypertension	Measles	Rheumatic Fever	Venereal Warts
Alcoholism	Eczema	Hepatitis	Mental problems	Sexual Abuse	Warts
Allergies	Epilepsy/Herpes	Miscarriage	Skin Disease	Whooping Cough	
Anaemia	Emphysema	Influenza	Mononucleosis	Strep Throat	Worms
Appendicitis	Gall Stones	Jaundice	Mumps	Sinusitis	Yellow Fever
Asthma	Goitre	Kidney Disease	Nosebleeds	Stroke	
Cancer	Gonorrhoea	Pneumonia	Parasites	Syphilis	
Chicken Pox	Gout	Leukaemia	Tonsillitis	Thyroid problems	Other: _____
Cold Sores	Hay Fever	Liver Disease	Prostatitis	Tuberculosis	
Depression	Heart Trouble	Malaria	Psoriasis	Urticaria	_____

**332 Dupont Street
Toronto, ON M5R 1V9
Tel: 416-535-5995**

**ONTARIO
COLLEGE OF
HOMEOPATHIC
MEDICINE**



Please list any major surgeries you have had in the past.

Have you had any injuries?

What vaccinations have you had? Did you or do you have any adverse reactions?

Have you lost any weight recently? How much?

Please check any of the following ailments which may be present in your family history:

Alzheimer's Alcoholism Cancer Diabetes Depression
 Gonorrhoea Hypertension Heart Disease Hepatitis Mental problems
 Skin Disease Syphilis Tuberculosis _____ _____

Relationship	Age	If deceased, age at death	Cause of Death	Diseases
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Sister (s)				
Brother (s)				
Aunt (s)				
Uncle (s)				
Children				

Please list the name and phone number of your family physician.

Have you been treated by a Homeopath before? If yes, what is his/her name?