Benna Lun BScH ND
Naturopathic Doctor

Today's Date: ________________________________

PATIENT INFORMATION (Please print in block letters)

Name: ____________________ ____________________ ____________________
First name Middle name Last name

How would you like us to address you? ________________________________

Date of Birth (MM/DD/YYYY): ______________ Current Age: ______ Sex: ______________

Address: ____ __________
Street address Apartment #

____________________ ______________ ______________
City Postal code Province

Please provide your contact information below and indicate whether or not we may leave messages relating to your appointments:

		Message?			Message?
(H) phone			Cell		
(W) Phone			Email		

EMERGENCY CONTACT INFORMATION

Name: ________________________________ Relationship: ____________________

Phone numbers: H: ( ) ____________________ OTHER: ( ) ____________________

HOW DID YOU HEAR ABOUT DR. LUN?

- ☐ Website
- ☐ Passing by clinic
- ☐ Pamphlet/Flyer
- ☐ Clinic patient
- ☐ Referred by another patient
- ☐ Referred by staff member
- ☐ Referred by health care provider: ____________________
- ☐ Other (please specify: ____________________ ____________________

HEALTH CARE PROVIDERS

Please list the other health care providers from whom you currently receive treatment:

Name: ____________________ Name: ____________________

Type of care: ____________________ Type of care: ____________________

Address: ____________________ Address: ____________________

____________________ ____________________

Phone: ( )____________________ Phone: ( )____________________

Fax: ( )____________________ Fax: ( )____________________

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Health care providers (continued)

Name: ______________________________
Type of care: ______________________________
Address: ______________________________
____
Phone: (   )______________________________
Fax: (   )______________________________

Name: ______________________________
Type of care: ______________________________
Address: ______________________________
____
Phone: (   )______________________________
Fax: (   )______________________________

Do you have regular screening tests with another Dr. (e.g. blood tests, PAP, etc.)? (Please circle) Yes No

CHIEF CONCERNS

Please list the top health care concerns for which you are seeking treatment in order of importance to you:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

MEDICAL HISTORY

How is your general state of health? (Please circle) Excellent Good Average Fair Poor

Please list any past health concerns, including major illnesses, hospitalizations, surgeries, etc., with approximate dates:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Do you have any allergies (medication, seasonal, environmental, etc.)?
(Please circle) Yes No

If yes, please describe: ______________________________
____

If you are female, are you currently pregnant or are hoping to become pregnant in the near future?

(Please circle) Yes No

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Please complete the following table regarding medications and supplements:

CURRENT medications			
Drug name	Date started	Dose	What is this drug being taken for?
PAST medications			
Drug name	Date ended	Dose	What was this drug being taken for?
CURRENT supplements (including vitamins, minerals, herbs, homeopathics, etc.)			
Supplement name	Date started	Dose	What is this supplement being taken for?

Do you use any over-the-counter (non-prescription) medications? Please list:

____

____

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Please complete the following table:

	Amount per day/week/month
Caffeine (coffee, chocolate, tea, etc.)	
Tobacco (cigarettes, chewing tobacco, etc.)	
Alcohol (beer, wine, liquor, etc.)	
Recreational drugs (marijuana, cocaine, heroin, etc.)	

IMMUNIZATION HISTORY

Is there anything remarkable about your immunization history? Please describe: ___________________________

____

Have you ever experienced a negative reaction from an immunization, including the “flu” shot? Please describe:

____

____

DIET

What do you eat on a typical day? Please indicate examples and quantities.

Breakfast: ____

____

Lunch: ____

____

Supper: ____

____

Snacks: ____

Beverages: ____

Are your meals usually prepared at home or purchased? __________________________________

Do you have any food allergies, sensitivities, or intolerances (that you know of)? Yes No

Please describe: ____

____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? Yes No

Please describe: ____

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FAMILY MEDICAL HISTORY

Please indicate any health conditions occurring in your family. Include parents, siblings, children, grandparents, aunts, and uncles.

Health condition	Family member(s)
Heart disease (heart attack, stroke, etc.)	
High blood pressure	
Diabetes	
Asthma	
Eczema or other skin condition	
Thyroid disease (Hypo or Hyper?)	
Arthritis/Rheumatism/other muscle or joint condition	
Cancer (Please indicate type)	
Mental illness (e.g. depression, anxiety, schizophrenia, etc)	
Environmental/seasonal allergies	
Other (please describe):	

☐ I don't know my family medical history

ENVIRONMENT

What is your current occupation? ______________________________

Past occupations that relate to your case? ______________________________

What are your hobbies?______________________________

____

Do you exercise? Please describe types and amounts of activities: ______________________________

____

____

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Are you exposed to significant amounts of smoke (including tobacco smoke) or other forms of pollution through work, hobbies, home environment, etc.? (Please circle) Yes No

Please describe: ____

____

Are you frequently exposed to animals (including pets)? (Please circle) Yes No

Please describe: ____

____

How is your home heated? ____

How would you describe the emotional climate of your home? ______________________

____

____

____

How stressful is your work and other aspects of your life? ______________________

____

____

____

How well do you feel you handle stress? ______________________________

____

____

____

Is there anything you feel is important that has not been covered? ______________________

____

____

____

Thank you for taking the time to complete this form