Advanced WELLNESS CENTRE
Lending a hand to your health

10 Talbot Street East, Leamington

Name: _____ Date: _____

Street Address: _____ Phone: _____

City: _____ Prov.:_____ Postal Code: _____

Date of Birth: _____ Sex: □ Male □ Female

Health Card Number: _____

Email Appointment Reminders: _____

What is the reason for seeking care today? _____

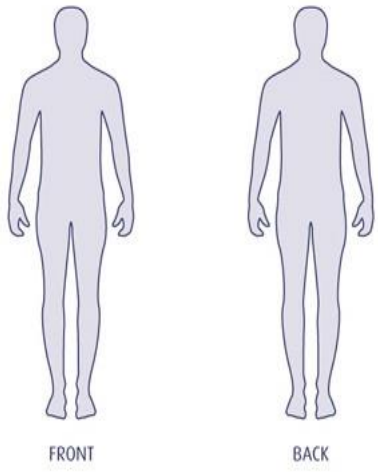
_____

Do you have current health problems: (include when started)_____

_____

_____

Please mark where you feel your complaint?



Name of Family Physician: _____ City: _____

Do you have private insurance? Yes □ No □ Insurance Company: _____

Is your injury the result of: □ work related injury □ car accident □ neither

Have you recently seen other healthcare provider for this issue: _____

List current medications: _____

List any past surgery: _____

List any past injuries/accidents: _____

List any x-rays, MRIs, CTs or other test: _____

_____

In order to provide the best care possible, we need to understand your general health status. Please check the following that applies to you:

□ Fever
□ Weight changes
□ Feeding/eating problems
□ Headaches
□ Blurred / Double Vision
□ Eye Pain
□ Allergies
□ Seizures
□ Weakness
□ Numbness/tingling
□ Excessive thirst
□ Too Hot/Cold
□ Tired/Sluggish
□ Abdominal Pain
□ Nausea/Vomiting
□ Digestion Issues

□ Constipation
□ Diarrhea
□ Chest Pain
□ Neck Pain / Back Pain
□ Arthritis
□ Ear infection
□ Sore Throat
□ Sinus Problems
□ Urine Infection
□ Wetting Accidents
□ Urinary Frequency
□ Wheezing
□ Frequent Cough
□ Pneumonia
□ Asthma
□ Infections

□ HIV/AIDS/other STDs
□ Blood Clotting Problem
□ Personality changes
□ Hyperactivity
□ Difficulty concentrating
□ Memory trouble
□ Smoking
□ Drinking
□ Drug use
□ Caffeine
□ Soft drinks
□ Car accident
□ Major falls
□ Broken bones
□ Head trauma
□ Sports injury

Do you or anyone in your family have the following:

□ Diabetes
□ Thyroid Disease
□ Tuberculosis
□ Kidney Disease
□ High Blood Pressure
□ Cancer
□ Bone, muscle or nerve disease
□ Lung Disease
□ Ulcers
□ Arthritis
□ Seizures/Strokes

I confirm that the above information is true to the best of my knowledge.

Patient Signature:_____