# PATIENT HISTORY

(Please print)

Name: _____ MHSC: _____

Address: _____ PHIN: _____

Date of Birth: ___/___/_____(D/M/Y) Height: ___' ___" Weight _____ lbs

Telephone: _____ (home) _____ (work) _____ (cell)

Email: _____Alternate tel. number/contact: _____

Family Doctor (Name/address): _____

Reason for Referral: _____

Medical History (ie: Diabetes, Hypertension, etc.): _____

_____

Past Surgical History: _____

_____

Medications (including vitamins/over-the-counter medications)

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Allergies: _____

Social History: Occupation _____ Marital status: _____

_____Children Alcohol: _____drinks/week Smoking: _____ packs/week