DR. AARON VAN GAVER

NATUROPATHIC DOCTOR
ADDICTION COUNSELLOR

Health History Questionnaire

Naturopathic health care and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. This information will remain confidential. Please mark anything you do not understand with a question mark.

Personal Information – Please Print

Last name: _____First name: _____

Age:_____ Date of Birth: _____/_____/_____/ Sex: _____
month day year

Birth time: _____ Birth Place : _____

Address: _____

City: _____ Province:_____ Postal Code:_____

Telephone: (Home)_____ (Work/cell)_____

Occupation: _____Email address:_____

Are you: Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Significant partnership☐

Live with: Spouse ☐ Partner ☐ Friends ☐ Other ☐ Children ☐ How many?_____

When and where did you last receive medical or health care?

_____

What was the reason?

_____

What your most important health concerns?

1._____
2._____
3._____
4._____
5._____
6._____

How did you hear about Dr. Van Gaver?

Patient ☐ Friend ☐ Referral ☐ Yellow Pages ☐ Seminar ☐ Other ☐

Can Dr. Van Gaver use portions of your information for Research Purposes? _____
(Information collected would respect patient privacy – no names or identifying information would be used)

CHECK THOSE APPLICABLE

	Father	Mother	Brother(s)	Sister(s)	Spouse	Child	Child
Health (G=Good, P=Poor)							
Cancer							
Diabetes							
Heart disease							
High blood pressure							
Stroke							
Epilepsy							
Mental illness							
Asthma, Hayfever, Hives							
Anemia							
Kidney disease							
Glaucoma							
Tuberculosis							
Age (if living)							
Age at death (if applicable)							
Cause of death							

For the following sections, please circle Y=Yes N=No

CHILDHOOD ILLNESSES

Scarlet fever	N	Y	Diptheria	N	Y	Rheumatic fever	N	Y
Mumps	N	Y	Measles	N	Y	German measles	N	Y

Other _____

HOSPITALIZATION AND/OR SURGERY

What hospitalizations or surgeries have you had?

_____

_____

X-RAYS AND SPECIAL STUDIES: What X-rays, CAT scans or MRIs have you had?

_____

_____

Electrocardiogram N Y Electroencephalogram N Y

IMMUNIZATIONS

Polio	N	Y	Pertussis	N	Y
Tetanus (shot, not anti-toxin)	N	Y	Diptheria	N	Y
Measles/Mumps/Rubella	N	Y	Other _____		

ALLERGIES
Please list any foods, drugs or other things you are allergic to:
_____
_____

CURRENT MEDICATIONS
Do you take or use:

Laxatives	N	Y	Pain relievers	N	Y	Antacids	N	Y	Cortisone	N	Y
Appetite suppressants	N	Y	Sleeping Aids	N	Y	Thyroid medications	N	Y	Tranquilizers	N	Y

List all prescriptions, over the counter medications, vitamins/supplements you are taking, including dose. (please use blank space at bottom of page if you need).

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

PLEASE ANSWER: N=Never P=Condition had in the past Y=Condition you have now

GENERAL

Weight: _____

Weight 1 year ago: _____

Maximum weight: _____

When: _____

Height: _____

Date of last physical exam: _____

Fatigue	N	P	Y
Headache	N	P	Y

SKIN

Acne, boils	N	P	Y
Colour changes	N	P	Y
Eczema, hives	N	P	Y
Itching	N	P	Y
Lumps	N	P	Y
Night sweats	N	P	Y

EYES

Impaired vision	N	P	Y
Glasses or contacts	N	P	Y
Eye pain	N	P	Y
Tearing or dryness	N	P	Y
Double vision	N	P	Y
Glaucoma	N	P	Y
Cataracts	N	P	Y

EARS

Impaired hearing	N	P	Y
Ringing	N	P	Y
Earache	N	P	Y
Dizziness	N	P	Y

NOSE & SINUSES

Frequent colds	N	P	Y
Nose bleeds	N	P	Y
Stuffiness	N	P	Y
Hay fever	N	P	Y
Sinus problems	N	P	Y

MOUTH & THROAT

Frequent sore throat	N	P	Y
Gum problems	N	P	Y
Hoarseness	N	P	Y
Sore tongue	N	P	Y

NECK

Goitre	N	P	Y
Lumps	N	P	Y
Pain or stiffness	N	P	Y
Swollen glands	N	P	Y

NEUROLOGICAL

Fainting	N	P	Y
Seizures	N	P	Y
Paralysis	N	P	Y
Muscle weakness	N	P	Y
Numbness or tingling	N	P	Y
Loss of memory	N	P	Y

RESPIRATORY

Tuberculosis	N	P	Y
Cough	N	P	Y
Sputum	N	P	Y
Spitting up blood	N	P	Y
Wheezing	N	P	Y
Pleurisy	N	P	Y
Asthma	N	P	Y
Bronchitis	N	P	Y
Pneumonia	N	P	Y

Emphysema	N	P	Y
Pain on breathing	N	P	Y
Shortness of breath	N	P	Y
:at night	N	P	Y
:lying down	N	P	Y
:with exercise	N	P	Y

CARDIOVASCULAR

Angina/Chest pain	N	P	Y
High blood pressure	N	P	Y
Heart disease	N	P	Y
Murmurs	N	P	Y
Rheumatic fever	N	P	Y
Swelling in ankles	N	P	Y
Palpitations, fluttering	N	P	Y

GASTROINTESTINAL

Trouble swallowing	N	P	Y
Heartburn	N	P	Y
Change in thirst	N	P	Y
Change in appetite	N	P	Y
Nausea/vomiting	N	P	Y
Bowel movements	How often?	_____/ day	
Is this a change?		N	Y
Do you have “round pencil” thin stools?	N	P	Y
Any blood in your stool?	N	P	Y
Any undigested food in your stool?	N	P	Y
Is the colour of your stool usually brown?	N	P	Y
Belching or passing gas	N	P	Y
Jaundice (yellow skin colour)	N	P	Y
Liver disease	N	P	Y
Gall bladder disease	N	P	Y
Ulcer	N	P	Y
Hemorrhoids	N	P	Y

URINARY

Pain on urination	N	P	Y
Increased frequency in the day	N	P	Y
Increased frequency at night	N	P	Y
Inability to hold urine	N	P	Y
Frequent infections	N	P	Y
Kidney stones	N	P	Y

ENDOCRINE

Thyroid problems	N	P	Y
Hot flashes	N	P	Y
Excessive thirst	N	P	Y
Sugar cravings	N	P	Y

BLOOD

Anemia	N	P	Y
Easy bleeding or bruising	N	P	Y

FEMALE REPRODUCTIVE

Are you pregnant?	N	P	Y
Age menses began	_____		
Length of cycle	_____day s		
Bleeding between menses	N	P	Y
Are your cycles regular?	N	P	Y
Are you in menopause?	N	P	Y
Menopausal symptoms	N	P	Y
Pain during intercourse	N	P	Y
Excessive flow	N	P	Y
Birth Control	N	P	Y
What type?	_____		
No. of pregnancies?	_____		
No. of live births?	_____		
No. of miscarriages?	_____		
No. of abortions?	_____		

Difficulty conceiving	N	P	Y
Are you sexually active?	N		Y
Sexual difficulties	N	P	Y
Any abnormal PAP smears?	N	P	Y
Last PAP smear			
Venereal disease (STD)	N	P	Y
Herpes	N		Y
Breast pain or tenderness	N	P	Y
Breast/nipple discharge	N	P	Y
Do you do breast self-exams?	N	P	Y
Mammogram?	N	P	Y
Mammogram results	_____		

MALE REPRODUCTIVE

Hernias	N	P	Y
Testicular masses/pain	N	P	Y
Are you sexually active?	N	P	Y
Sexual difficulties	N	P	Y
Venereal disease (STD)	N	P	Y
Herpes	N		Y
Discharge or sores	N	P	Y

PERIPHERAL VASCULAR

Deep leg pain	N	P	Y
Cold hands/feet	N	P	Y
Varicose veins	N	P	Y
Thrombophlebitis	N	P	Y

EMOTIONAL

Depression	N	P	Y
Mood swings	N	P	Y
Anxiety or nervousness	N	P	Y
Anger/frustration	N	P	Y
Ever treated for any of these?	N		Y

HABITS

What are your main interests and hobbies

1. _____

2. _____

3. _____

Do you eat three meals a day?	N		Y
How often do you exercise?	_____ / week		
What forms? _____			
Do you fall asleep OK?	N	P	Y
Once asleep, do you stay asleep?	N	P	Y
Awaken rested?	N	P	Y
Average sleep per night?	_____ hrs/night		
Enjoy your work?	N	P	Y

MISCELLANEOUS

When did you last take antibiotics?	_____		
Any tropical trips in the last 3 years?	N		Y
Have you ever had cancer?	N		Y
Have you ever been tested for HIV?	N		Y
Do you use recreational drugs?	N	P	Y
Been treated for drug dependence?	N	P	Y
Use tobacco or alcohol?	N	P	Y
Drink coffee or tea?	N	P	Y
Eat chocolate	N	P	Y
Drink “pop”	N	P	Y
How much?	_____x week		