



RICHMOND ALTERNATIVE MEDICAL CLINIC INC.

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Dr. Martin Kwok, ND

Dr. Leila Sahabi, ND

ADULT PATIENT PROFILE

Date: _____

FULL NAME _____ AGE _____ ^{MM/DD/YY} BIRTHDAY _____ SEX _____

ADDRESS _____ Postal Code: _____

HOME PHONE #: _____ WORK PHONE #: _____

CELLPHONE #: _____ PREFERRED CONTACT #: (please circle) work / home / cell

OCCUPATION _____ EMPLOYER _____

NAME OF EMERGENCY CONTACT _____ PHONE# _____

NAME OF YOUR PRIMARY PHYSICIAN _____ PHONE# _____

KNOWN ALLERGIES (food, drugs, vaccines, or environmental) _____

How did you hear about the clinic? (mark one or more) Friend BCNA Newspaper
 Yellow Pages others, specify _____

Note to patients: Please complete this two-sided questionnaire as thoroughly as possible in order to aid the physician in his diagnosis and treatment. This is a confidential record, and will **NOT** be released unless you have authorized us to do so. Thank you.

PRESENT HEALTH PROBLEMS/CONCERNS: Please list in the order of priority to YOU

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

LIST OF MEDICATIONS CURRENTLY TAKING: (prescription & over-the-counter drugs, vitamins, herbs, homeopathic remedies, etc.)

- | | |
|------------------------|------------------------|
| 1) _____ dosage: _____ | 5) _____ dosage: _____ |
| 2) _____ dosage: _____ | 6) _____ dosage: _____ |
| 3) _____ dosage: _____ | 7) _____ dosage: _____ |
| 4) _____ dosage: _____ | 8) _____ dosage: _____ |

PAST MEDICAL HISTORY:

Hospitalization (when, for what, and how long): _____

Accidents and injuries: _____

Psychiatric illnesses: _____

Patient Name: _____

Last complete physical exam date: _____ Describe any abnormal findings: _____
 Last PAP smear (woman only) date _____ Were the results: normal abnormal
 Last mammogram (woman only) date: _____ Were the results: normal abnormal
 Do you do monthly self-breast-exam? Y N

PERSONAL LIFESTYLE: (check & fill in applicable ones)

Habits:

Tobacco? N Y, how many years?_____, how many cigarettes per day now? _____
 Caffeine (coffee, tea, or pop)? N Y, how much daily _____
 Alcohol? N Y, how much _____
 Recreational drugs? N Y, what kind _____, how much _____
 Regular exercises? N Y, what kind _____, how often _____

Diet:

Describe your average day meals:

Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____

List foods that you crave: _____

Are there any diet restriction or regimens that you follow? Please describe: _____

Sleep:

Average hours of sleep per night: _____ Do you take pills or herbs to help you sleep? Y N
 Do you have difficulty sleeping? daily often sometimes never
 Do you dream? daily often sometimes never

SOCIAL HISTORY:

Marital status: single married significant other/common law widowed
 Sexual orientation: heterosexual homosexual bisexual
 Sexually active: Y N Type of birth control: _____
 How many children?_____,ages: _____

FAMILY HISTORY: Check and fill in applicable boxes (blood relations)

	Who	Comments		Who	Comments
Allergies			Heart Disease		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Auto Immune			Kidney disease		
Asthma			Mental Illness		
Cancer			Stroke		
Diabetes			Tuberculosis		
Epilepsy			Other		