

PERSONAL HISTORY

(Confidential: All information in this form remains confidential and will be released only on your written permission)

FULL NAME _____ BIRTHDATE ^M / ^D / ^Y _____ AGE _____
 NAME YOU PREFER TO BE CALLED _____ SEX _____ MARITAL STATUS S M D W
 ADDRESS _____ CITY _____ POSTAL CODE _____
 OCCUPATION _____ EMPLOYER _____
 WORK PHONE _____ HOME PHONE _____ CELL PHONE _____
 FAMILY PHYSICIAN _____ EMAIL ADDRESS _____
 WHO REFERRED YOU TO THIS OFFICE? _____

HEALTH PROBLEMS: LIST YOUR MAIN HEALTH CONCERNS/SYMPTOMS

1) _____ WHAT TREATMENTS HAVE BEEN TRIED? _____
 2) _____
 3) _____

MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING? (CIRCLE)

ANEMIA	RHEUMATIC FEVER	HEART ATTACK	SURGERIES (YEAR&TYPE) _____
HEPATITIS/LIVER DISEASE	KIDNEY STONES	HIGH BLOOD PRESSURE	_____
HAYFEVER	ASTHMA	PNEUMONIA	_____
TUBERCULOSIS	CANCER OF _____	BLADDER/VAGINAL INFEC.	_____
STOMACH ULCERS	MIGRAINE HEADACHES	ABNORMAL PAP TEST	HOSPITALIZATIONS (YEAR & REASON) _____
MEASLES	MUMPS	PROSTATE PROBLEMS	_____
COLITIS	ARTHRITIS/RHEUMATISM	BLEEDING TENDENCIES	_____
BLOOD CLOTS	HIVES	MONONUCLEOSIS	_____
GALLBLADDER PROBLEMS	THYROID PROBLEMS	SEXUALLY TRANSMITTED	INJURIES/ACCIDENTS (YEAR & CAUSE) _____
ANGINA/CHEST PAIN	HEART DISEASE	DISEASE	_____
POLIO	DIABETES	ECZEMA	_____
STROKE	ALCOHOL/DRUG ABUSE	DEPRESSION	OTHER CONDITIONS _____
EPILEPSY	MENTAL DISORDER	EATING DISORDER	_____
SMOKER? (Y OR N)			

FAMILY HISTORY: INCLUDING BLOOD RELATIVES ONLY

FATHER (age)* _____ BROTHERS (ages)* _____
 MOTHER (age)* _____ SISTERS (ages)* _____
 *If deceased, Please list age of death and circle.
 HAVE ANY OF THE ABOVE HAD THE FOLLOWING? (Circle)
 DIABETES KIDNEY DISEASE STOMACH ULCERS
 HEART DISEASE ASTHMA HIGH BLOOD PRESSURE
 ALLERGIES ARTHRITIS NERVOUS BREAKDOWN
 GOUT COLITIS BLEEDING TENDENCIES
 ALCOHOLISM TUBERCULOSIS PSYCHIATRIC ILLNESS
 CANCER STROKE GALLBLADDER PROBLEMS

WOMEN ONLY – CHILDBIRTH HISTORY

NUMBER OF CHILDREN _____ AGES _____
 NUMBER OF PREGNANCIES _____ DELIVERIES _____
 MISCHARRIAGES ___ ACCIDENTAL ___ INDUCED ___
 COMPLICATIONS _____
 BIRTHCONTROL METHODS: IN PAST _____
 NOW _____
 ARE YOU PREGNANT AT THIS TIME? _____

KNOWN ALLERGIES (including medicines, pollens, animals, foods & Chemicals): _____

CURRENT MEDICATIONS (list all prescription & over the counter medicines, vitamins, minerals, herbs that you take): _____

MEDITRINE NATUROPATHIC MEDICAL CLINIC

The doctors and staff at our clinic welcome you!

Meditrine Naturopathic Medical Clinic fees are as follows for all doctors:

First Office Visit (30-45 mins.)	\$ 110.00
Return Office Visit (15-30 mins)	\$ 75.00
Brief Office Visit (10-15 mins.)	\$ 42.00
Extended Office Visit (45-60 mins.)	\$ 145.00
Acupuncture (30 mins.)	\$ 75.00
Physical & Pap (30-45 mins.)	\$ 112.00
Initial Food Allergy Test	\$ 110.00
Food Allergy Retest	\$ 50.00
Blood Typing	\$ 15.00

We accept VISA, Mastercard, Debit and Cash. We do not accept cheques.

There's a **full charge fee** for missed doctor visits or for those rescheduled/cancelled with less than 24 hours notice & an additional fee of \$40 for any missed allergy test/retest. Please remember, with less than 24 hours notice, it's difficult for others to come and fill your vacant appointment time.

Fees for office visits, laboratory services and medicine items are due at the time of service.

Most extended medical plans provide coverage for visits, lab and food allergy tests. Please save your receipts for this extended coverage, as we will not be able to issue another receipt. A \$10.00 charge will apply for extended reports.

Custom made or special order medicines are to be paid for before they are ordered or made. There are also no rebates on quantity of medicine items ordered.

Any natural hormone alternatives, that you may be prescribed, are refillable only under doctor authorization; otherwise a follow-up visit is required. This is a mandatory clinic policy.

Please be aware that at times prices for medicines may decrease, increase or stay the same. This reflects exact current pricing that we are charged by our suppliers and US exchange rates.

I have read the above and agree to comply with the terms stated above.

Signature _____

Date _____

Enjoy Your Visit!
The Meditrine Team