Patient Health Summary

File Number:_____

TG Wellness Clinic

1420 Burnhamthorpe Road East Mississauga Tel: 9056290820

Patient Information		
First Name:	Last Name:	Middle Name:
Telephone (Home/Mobile):	Telephone (Business):	Sex: M / F / Other
Home/Street Address:	Apt #:	Date of Birth: (DD/MM/YY)
City: Province:	Postal Code:	Marital Status:
Occupation:	Email:	
Family Contact Information	First name:	Last name:
Relationship to Patient:	Phone Number:	Mobile Number:
Emergency Contact information (If different individual from above)	First name:	Last Name:
Relationship to Patient:	Phone Number:	Mobile Number:
Family Doctor Name:		
Clinic Address:		
Clinic Phone:	Clinic Email:	

Past Medical History

Please list any relevant past medical history including any hospitalizations, surgeries, prior injuries, or any past medical conditions etc. Be sure to include any previous family medical conditions or diseases that may be relevant.

Ongoing Health Conditions/ Allergies/Drug Reactions/ Risk Factors/Long Term Treatment

Please list any ongoing health conditions, allergies, drug reactions, and long term treatments that may be relevant. If you are currently taking any prescription medications, please include them.

Date of Last Update of Patient Health Summary:

Symptoms

1. Body & limbs: Cold/Hot/Normal Aversion to Cold/Wind / No
   Fatigue/Lassitude: Yes/No Heavy sensation: Head/Limbs / No
2. Sweating: at day/night /No Hot Flush Yes/ No Hot Sensation Palm/Foot Sole
3. Thirsty: Yes/No Prefer Warm/Hot or Cool/Cold / Iced
4. Sleep: Normal/Insomnia/Somnolence ---------Dream disturbed/Tinnitus
5. Appetite: Good/Bad ----------Prefer taste: Sweet/Sour/Bitter/Salty/Spicy
6. Blood Pressure: Normal/High/Low------Dizziness/Chest Distress/Palpitation/Short Breath/Edema
7. Pain:

   -----Fixed/Wandering-----Persistent/Paroxysmal
   Sharp/Colicky/Stabbing/Dull/Cold/Burning/Distending/Pulling/Aching/Swelling
8. Bowel movement: How frequent
   Stools: Formed/Dry/Loose/Diarrhea/Constipation/With blood
9. Abdominal pain/Borborygmus/Belching/Hiccup/Nausea/Vomiting/Acid Reflux
10. Taste in the mouth normal / bitter /metal/ other
11. Chest/Hypochondriac: Fullness/Distention/Pain/ No Blurred Vision: Yes/No
12. Urination: Normal/Frequent/Unsmooth/Not clear-------How often at Night urine:
    Colour of urine: dark yellow / yellow / white
13. Emotion: Stable/Mood swings/Stress/Irritability/Depression/Anxiety/Sigh.
14. Please list any other concerns or conditions you may have:

15. Answer by women of appropriate age: Menstrual Cycle: Normal/Early/Delayed,
    Period length: ; --Colour: Light Red/Bright Red/Dark Red; ---Blood clots: None/Little/Lots; Volume: Light/Normal/Heavy; ----Dysmenorrhea/Breast Distention/Headache/Back Pain/Fatigue---Happen in: Premenstrual/During menstrual/Postmenstrual. ----Vaginal Discharge: Normal/Heavy/Light
    Date of last period:

Have you had any of the following?

Appendicitis	Malaria	Chicken pox	Alcoholism	Osteoporosis
Diabetes	Venereal infection	Cold sores	Whooping couch	Cancer
Epilepsy	Multiple sclerosis	Anemia	Heart disease	Tuberculosis
Pneumonia	Measles	Goiter	Eczema	Mental illness
Mumps	Influenza	Gout	Polio	Pleurisy
Pneumatic fever	Arthritis	Rubella	Parkinson's	HIV/AIDS
Pace maker	Hepatitis B			

Signature of Patient: _____ or Substitute Decision-Maker: _____

Date:_____ Relationship to Patient: _____

Date of Last Update of Patient Health Summary: