Patient Health Summary

GJ-TCM clinic Centre
10 East Wilmot St, Unit 6. Richmond Hill, ON L4B 1G9
Tel: 905-731-6555 www.gjtcm.ca

File Number:_____

Internal use only
Practitioner:
Registration#
Date:

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:

Please circle any conditions you are experiencing (past and present):

General Symptoms
Headaches/migraines
Fever
Chills
Sweat
Memory loss
Dizziness/Light headiness
Fainting
Stress/depression
Discoordination
Nervousness
Recent weight loss/gain
Numbness pain in arms, legs

Respiratory
Wheezing
Chronic cough
Spitting up phlegm
Chest pain
Difficulty breathing

Muscle and Joint
Stiff neck
Back ache
Swollen joints
Painful tailbone
Pain in shoulder
Hernia
Spinal curvature
Faulty posture
Arthritis
Foot trouble

Cardiovascular
High or low blood pressure
Previous stroke or TIA
High cholesterol

Swelling of ankles
Poor circulation
Stroke/heart attack
Irregular heart beat
Shortness of breath
Pain over heart

Genitourinary System
Frequent/painful urination
Blood in urine/stool
Mucus in stool
Kidney infection/kidney stone
Bladder infection
Inability to control urine

Ears, Eyes, Nose, Throat
Hearing loss
Vision problems
Glaucoma
Ringing in ear(s)
Crossed eyes
Eye pain
Deafness
Earache
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Hay fever
Asthma

Dental decay
Gum trouble
Frequent colds
Enlarged thyroid

Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands

Skin
Skin conditions/rashes
Itching
Bruise easily
Dryness
Boils
Varicose veins
Sensitive skin
Hives or allergy

Gastrointestinal
Poor appetite
Distress from greasy foods

Excessive hunger/thirst
Belching or gas
Nausea
Vomiting
Burning in stomach
Pain over stomach
Constipation/diarrhea
Colon trouble
Liver trouble/hepatitis
Gall bladder
Ulcers
Colitis
Hemorrhoids
Hypoglycemia
Hiatal hernia

Metallic taste

For Women Only
Cramps/backache
Previous miscarriage
Irregular cycle
Vaginal discharge
Lumps in breast
Menopausal symptoms

Pregnant
Painful menstruation
Excessive flow
Hot flashes
Hysterectomy

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

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

Date:_____ Relationship to Patient: _____

Date of Last Update of Patient Health Summary: