Wholeness Family Clinic Health History **Female**

Last Name: ______________________________________ Date of Birth: ___/____/____
First Name(s): ____________________________________ d m y
Health Number: __________________________________
Civic Address: ____________________________________ Phone #: _______________
PO Box ____________________________________ Work #: ________________
Town/P Code ____________________________________ Cell #: _________________

Email Address: ____

Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced ☐ separated
☐ common law ☐ same sex
Spouse or Partner's Name: _________________________

Occupation: ____________________ Employer: ___________________________

Have you had (or have) any of the following diseases?
☐ Allergies ☐ Chronic Bronchitis ☐ High Blood Pressure
☐ Arthritis ☐ Diabetes ☐ Nerves
☐ Asthma ☐ Heart Trouble ☐ Skin Problems
☐ Cancer ☐ Other: ____

Have you had any of the following operations? Indicate which year.
☐ Appendectomy ____ ☐ Hysterectomy ____ ☐ Gall Bladder ____
☐ Breast Surgery ____ ☐ Other: ___________________________________

Do you have a strong family history of any of the following?
☐ Cancer ☐ Heart Attacks ☐ High Blood Pressure
☐ Diabetes ☐ Other: ____

Medications: Please list all the medications that you regularly take.
____
____

Indicate: number of pregnancies _____ number of living children _____

Allergies: Please list all drug allergies.
____

Do you exercise or walk regularly? ☐ no ☐ once or twice a week
☐ daily ☐ very athletic

Do you smoke? ☐ never ☐ less than 1 pack/day ☐ 1 pack/day or more
☐ quit (# of years___)

Do you drink alcohol? ☐ never ☐ regularly (# of drinks / week ___)
☐ occasionally ☐ quit (# of years of sobriety ___)

For patient information visit **www.wholenessfc.com** *"finding abundant health"*