

Wholeness Family Clinic Health History

Male

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 _____ Hernia Repair _____ Gall Bladder _____
- Prostate _____ 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.

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 / day ___)
 occasionally quit (# of years of sobriety ___)

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