



Customized Vitamin Questionnaire

Name:

Address:

Postal Code:

Phone Number:

Date of Birth:

Sex:

Family Physician:

Referred By:

What are your main health concerns? List in order, from most important to least

1.

2.

3.

4.

5.

Medical History – General

Date of last physical exam: _____

Weight: _____ Maximum Weight: _____

Height: _____

Blood Type: _____

Date of last blood test _____

Hours of Sleep _____

Number of times you wake up _____

during the night: _____

Number of Meals per day: _____

Do you have a special diet: _____

Please mark those that apply

Do you Eat Tuna? How Often? _____

So you Eat Swordfish? How Often? _____

Do you use antiperspirant? What Brand? _____

Do you use a Deodorant? What Brand? _____

Do you smoke? If you quit, how
long ago? _____

Have you used Recreational Drugs? What kind? _____

Do you Have Allergies? What kind? _____

Do you have any implants or transplants? What type? _____

Childhood Diseases (please circle)

Measles/ Rubella	German Measles	Chickenpox	Diphtheria	Whooping Cough	Mumps
Rheumatic fever	Scarlet fever	Polio	Meningitis	Mononucleosis	Smallpox

Other:

Vaccinations (please circle)

Pertussis Rheumatic fever Polio Mumps Measles Rubella
Tetnus Smallpox Other:

Did you have any reactions to these vaccinations: Yes/No

If yes what type of reaction?

X-Rays (please circle)

Teeth Stomach Gall bladder Back Chest Colon Extremities
Other:

EKG? Yes/No When: _____

EEG? Yes/No When: _____

Blood or Plasma Transfusions? Yes/No When: _____

Review of Body systems (Circle Y for Yes present and P for Yes in the past)

General:		Skin:	
Cancer	Y/P	Rashes	Y/P
Sensitivity to cold	Y/P	Psoriasis	Y/P
Excessive hair loss	Y/P	Boils	Y/P
Sudden tiredness/ weakness	Y/P	Scabies	Y/P
Time of Day _____		New moles or change in old moles	Y/P
Fever/chills	Y/P	Hives	Y/P
Rapid weight gain/loss	Y/P	Acne	Y/P
Sweat easily/ excessively	Y/P	Dry skin	Y/P

Family History (please check those that apply)

Condition	Family Member
Cancer (What type?) <input type="radio"/>	_____
Hereditary Disease (What Type?) <input type="radio"/>	_____
Skin Allergies <input type="radio"/>	_____
Eczema/Psoriasis <input type="radio"/>	_____
Arthritis/ Gout <input type="radio"/>	_____
Kidney Disease <input type="radio"/>	_____
Respiratory Allergies <input type="radio"/>	_____
Asthma <input type="radio"/>	_____
Lung Disease/TB <input type="radio"/>	_____
Liver Disease/Cirrhosis <input type="radio"/>	_____
Thyroid Problems/Obesity <input type="radio"/>	_____
High Blood Pressure <input type="radio"/>	_____
Arteriosclerosis/Vascular Disease/Stroke <input type="radio"/>	_____
Heart attack/Heart Disease <input type="radio"/>	_____
Nervous breakdown/Epilepsy <input type="radio"/>	_____
Syphilis <input type="radio"/>	_____
Gonorrhea <input type="radio"/>	_____
Miscarriages <input type="radio"/>	_____

Diet Log (Last 5 days)

How many meals have you eaten per day?						
How many Calories per day?						
How many serving of meat meat/protein						
How many servings of vegetables?						
How many servings of bright fruit how you eaten? (i.e. Blueberries, Strawberries, Citrus)						
How many servings of fiber?						
Amount of fluid consumed per day?						
How many servings of fish? (Last 7 days)						

How many alcoholic drinks to you have per week?

Do you drink coffee? Yes No

Do you drink dairy? Yes No

Do you take any supplements?

Thank you for filling out our questionnaire. Please return to the Medicine Shoppe
at 59 Great Northern rd. Sault Ste. Mare, Ontario