



**Dr. Michael Hoffmann, B.Sc., N.D.
Naturopathic Physician**

Name: _____ **Date:** _____

Check the symptoms/conditions which apply to you:

✓Generals

Current weight: _____	Current height: _____
<input type="checkbox"/> noticeable weight loss	<input type="checkbox"/> fatigue
<input type="checkbox"/> noticeable weight gain	<input type="checkbox"/> weakness
<input type="checkbox"/> fever	

Comments: _____

✓Skin

<input type="checkbox"/> rashes	<input type="checkbox"/> colour change	<input type="checkbox"/> lumps
<input type="checkbox"/> changes in hair/nails	<input type="checkbox"/> itching	<input type="checkbox"/> dryness
<input type="checkbox"/> eczema	<input type="checkbox"/> hives	<input type="checkbox"/> psoriasis
<input type="checkbox"/> boils	<input type="checkbox"/> moles	

Comments: _____

✓Head

<input type="checkbox"/> head injury	<input type="checkbox"/> headaches
<input type="checkbox"/> hair loss	<input type="checkbox"/> dandruff

Comments: _____

✓Eyes

<input type="checkbox"/> redness	<input type="checkbox"/> spots	<input type="checkbox"/> pain
<input type="checkbox"/> specks	<input type="checkbox"/> excessive tearing	<input type="checkbox"/> flashing lights
<input type="checkbox"/> double vision	<input type="checkbox"/> glaucoma	<input type="checkbox"/> blurred vision
<input type="checkbox"/> cataracts	<input type="checkbox"/> crossed eyes	<input type="checkbox"/> blind spot
<input type="checkbox"/> discharge	<input type="checkbox"/> bothered by the sun	

Do you wear glasses/contacts? _____

Date of last eye exam? _____

Comments: _____

✓Ears

_____ infection
_____ discharge

_____ ringing in ears (tinnitus)
_____ earaches

_____ vertigo
_____ hearing loss

Do you use hearing aids? _____

Date of last hearing test? _____

Comments: _____

✓Nose and Sinuses

_____ frequent colds
_____ nasal stuffiness
_____ loss of smell

_____ hay fever
_____ discharge
_____ sinus infections

_____ nosebleeds
_____ itching

Comments: _____

✓Mouth and Throat

_____ dry mouth
_____ sore tongue
_____ spots/sores in mouth
_____ heat/cold intolerance
_____ lumps in neck
_____ tonsillitis
_____ stiff neck

_____ bleeding gums
_____ hoarseness
_____ dental cavities
_____ sore throat
_____ loss of taste
_____ enlarged thyroid

Date of last dental exam? _____

Comments: _____

✓Respiratory

_____ sputum
_____ hemoptysis
_____ wheezing
_____ asthma
_____ tuberculosis
_____ chest pain

_____ cough
_____ bronchitis
_____ emphysema
_____ pneumonia
_____ pleurisy
_____ difficulty breathing

Results of spirometry tests or other lung tests:

Comments: _____

✓Cardiovascular

- | | |
|--|---|
| <input type="checkbox"/> rapid heart beat | <input type="checkbox"/> slow heart beat |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> heart murmurs |
| <input type="checkbox"/> low blood pressure | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> edema/swollen ankles |
| <input type="checkbox"/> palpitations | <input type="checkbox"/> difficulty breathing |
| <input type="checkbox"/> blueness of skin (cyanosis) | <input type="checkbox"/> cold hands/feet |
| <input type="checkbox"/> thrombophlebitis | <input type="checkbox"/> extremity numbness |
| <input type="checkbox"/> deep leg pain | <input type="checkbox"/> leg cramps |

Results of electrocardiogram or other heart tests:

Comments: _____

✓Gastrointestinal

- | | |
|--|--|
| <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> heart burn | <input type="checkbox"/> constipation |
| <input type="checkbox"/> excessive hunger/thirst | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> poor appetite/thirst | <input type="checkbox"/> hypoglycemia |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> abdominal pain |
| <input type="checkbox"/> nausea | <input type="checkbox"/> food intolerance/allergy |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> excessive belching |
| <input type="checkbox"/> regurgitation | <input type="checkbox"/> passing of gas |
| <input type="checkbox"/> vomiting of blood | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> indigestion | <input type="checkbox"/> liver or gallbladder problems |
| <input type="checkbox"/> hepatitis | <input type="checkbox"/> colitis |
| <input type="checkbox"/> ulcer | <input type="checkbox"/> hernias |
| <input type="checkbox"/> excessive bloating | |

Frequency of bowel movements? _____

Colour and size of stools? _____

Change in bowel habits? _____

Any recent bleeding or black tarry stools? _____

Comments: _____

✓Genito-Urinary

- | | |
|--|--|
| <input type="checkbox"/> dark-coloured urine | <input type="checkbox"/> blood in urine |
| <input type="checkbox"/> excessive urination | <input type="checkbox"/> frequency at night |
| <input type="checkbox"/> burning/pain on urination | <input type="checkbox"/> kidney infection |
| <input type="checkbox"/> pus in urine | <input type="checkbox"/> foul smelling urine |
| <input type="checkbox"/> urgency | <input type="checkbox"/> hesitancy |
| <input type="checkbox"/> dribbling | <input type="checkbox"/> incontinence |
| <input type="checkbox"/> urinary infections | <input type="checkbox"/> kidney stones |

Comments: _____

✓Musculoskeletal

- | | |
|--|--|
| <input type="checkbox"/> muscle or joint pains | <input type="checkbox"/> stiffness |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> gout |
| <input type="checkbox"/> back pain | <input type="checkbox"/> artificial joints/limbs |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> muscle spasms/cramps |
| <input type="checkbox"/> general muscle weakness | <input type="checkbox"/> joint swelling |

Comments: _____

✓Neurological

- | | |
|---|--|
| <input type="checkbox"/> fainting/blackouts | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> weakness | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> numbness/loss of sensation | <input type="checkbox"/> tingling/pins and needles |
| <input type="checkbox"/> tremors/involuntary motion | <input type="checkbox"/> speech problems |
| <input type="checkbox"/> nervousness | <input type="checkbox"/> tension |
| <input type="checkbox"/> depression | <input type="checkbox"/> memory changes/loss |
| <input type="checkbox"/> difficulties concentrating | <input type="checkbox"/> irritability |
| <input type="checkbox"/> convulsions/seizures | <input type="checkbox"/> loss of sleep |

Comments: _____

✓Hematological

- | | |
|--|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> any past transfusions |
| <input type="checkbox"/> easy bleeding | <input type="checkbox"/> easy bruising |

Any other conditions? _____

Comments: _____

Thank you for taking the time to complete this form