G. Ryder, M.D.
Suite 203 - 2786 West 16th Ave.
Vancouver, BC V6K 4M1
Tel: 604.737.7776
Fax: 604.737.7039
www.integrativemedicine.ca

PATIENT HISTORY INFORMATION FORM – Please Print Carefully

When completed, please return to office by mail or fax.
Upon receipt of completed form, you will be contacted regarding initial appointment.

Name: _____ _____ _____
SURNAME MIDDLE NAME FIRST NAME

Home Address: _____ _____ _____
Street Address City Province

Postal Code: _____ Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ _____ ___ **Present Age:** _____
Year Month Day

Place of Birth: _____ **Marital Status:** Single / Married / Divorced / Widowed

Occupation: _____ **If a Minor, Parents' Names:** _____

PHN (Care Card Number): _____ **Family Doctor:** _____

Please List Your Present Major Health Concerns (starting with the most troublesome to you):

	Since
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Date of Last Physical Examination (and by whom): _____

Any Abnormal Findings? _____

Please List Recent Blood Tests (include: when, which tests, and results or provide copies of): _____

_____

_____

Please List Recent X-Rays or Other Investigations including Conventional <u>and</u> Non-Conventional (include: when, which tests, and results): _____

_____

_____

_____

Other Health Practitioners You are Currently Seeing (or have recently seen):
Include: Family doctor, specialists, physiotherapists, naturopaths, chiropractors, massage therapists, acupuncturists, herbalists, etc.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ALL Current Medications (Prescription, Non-Prescription, Herbs, Vitamins, etc.) List on separate sheet if necessary.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Personal History

Smoker? _____

Alcohol? ___ Type? _____ Amount per week_____

Recreational Drugs? _____

Known Allergies? _____

_____

_____

_____

_____

Family History

Hayfever/Asthma/Eczema? _____

Heart Disease/Strokes? _____

Diabetes? _____

Cancer? _____

Depression? _____

Other Mental Disease? _____

Additional Medical History (Please provide in chronological order.)
Include any medical treatments and the results of these (also any non-conventional treatments such as infrared sauna, laser therapy, cosmetic treatments, electromagnetic treatment devices etc.), and all surgical operations.