

# Patient Health Summary

File Number: \_\_\_\_\_

**Green River Natural Health/Kimberly Hahn/Reg. #3282 (CTCMPAO) #15245 (CHO)**

**7550 Rama Road, Ramara ON L0K 2B0/705-689-6395**

**[kim@greenrivenaturalhealth.com](mailto:kim@greenrivenaturalhealth.com) or [kimberly.hahn2@gmail.com](mailto:kimberly.hahn2@gmail.com)**

Patient Information		
First Name:	Last Name:	Middle Name:
Telephone (Home/Mobile):	Telephone (Business):	Sex: M / F / Other
Home/Street Address:	Apt #:	Date of Birth: (DD/MM/YY)
City:	Province:	Postal Code:
Occupation:	Email:	
Family Contact Information	First name:	Last name:
Relationship to Patient:	Phone Number:	Mobile Number:
Emergency Contact information (If different individual from above)	First name:	Last Name:
Relationship to Patient:	Phone Number:	Mobile Number:
Family Doctor Name:		
Clinic Address:		
Clinic Phone:	Clinic Email:	
Past Medical History		
<i>Please list any relevant past medical history including any hospitalizations, surgeries, prior injuries, or any past medical conditions etc. Be sure to include any previous family medical conditions or diseases that may be relevant.</i>		
Ongoing Health Conditions/ Allergies/Drug Reactions/ Risk Factors/Long Term Treatment		
<i>Please list any ongoing health conditions, allergies, drug reactions, and long term treatments that may be relevant. If you are currently taking any prescription medications, please include them.</i>		

Date of Last Update of Patient Health Summary:

**Please circle any conditions you are experiencing (past and present):**

**General Symptoms**

Headaches/migraines  
Fever  
Chills  
Sweat  
Memory loss  
Dizziness/Light headedness  
Fainting  
Stress/depression  
Discoordination  
Nervousness  
Recent weight loss/gain  
Numbness pain in arms, legs

**Respiratory**

Wheezing  
Chronic cough  
Spitting up phlegm  
Chest pain  
Difficulty breathing

**Muscle and Joint**

Stiff neck  
Back ache  
Swollen joints  
Painful tailbone  
Pain in shoulder  
Hernia  
Spinal curvature  
Faulty posture  
Arthritis  
Foot trouble

**Cardiovascular**

High or low blood pressure  
Previous stroke or TIA  
High cholesterol  
Swelling of ankles  
Poor circulation  
Stroke/heart attack  
Irregular heart beat  
Shortness of breath  
Pain over heart

**Genitourinary System**

Frequent/painful urination  
Blood in urine/stool  
Mucus in stool  
Kidney infection/kidney stone  
Bladder infection  
Inability to control urine

**Ears, Eyes, Nose, Throat**

Hearing loss  
Vision problems  
Glaucoma  
Ringing in ear(s)  
Crossed eyes  
Eye pain  
Deafness  
Earache  
Ear discharge  
Nose bleeds  
Nasal obstruction  
Sore throat  
Hoarseness  
Hay fever  
Asthma

Dental decay  
Gum trouble  
Frequent colds  
Enlarged thyroid  
Tonsillitis  
Sinus infection  
Nasal drainage  
Enlarged glands

**Skin**

Skin conditions/rashes  
Itching  
Bruise easily  
Dryness  
Boils  
Varicose veins  
Sensitive skin  
Hives or allergy

**Gastrointestinal**

Poor appetite  
Distress from greasy foods  
Excessive hunger/thirst  
Belching or gas  
Nausea  
Vomiting  
Burning in stomach  
Pain over stomach  
Constipation/diarrhea  
Colon trouble  
Liver trouble/hepatitis  
Gall bladder  
Ulcers

Colitis  
Hemorrhoids  
Hypoglycemia  
Hiatal hernia

Metallic taste

**For Women Only**

Cramps/backache  
Previous miscarriage  
Irregular cycle  
Vaginal discharge  
Lumps in breast  
Menopausal symptoms  
Pregnant  
Painful menstruation  
Excessive flow  
Hot flashes  
Hysterectomy

**Have you had any of the following?**

Appendicitis	Malaria	Chicken pox	Alcoholism	Osteoporosis
Diabetes	Venereal infection	Cold sores	Whooping cough	Cancer
Epilepsy	Multiple sclerosis	Anemia	Heart disease	Tuberculosis
Pneumonia	Measles	Goiter	Eczema	Mental illness
Mumps	Influenza	Gout	Polio	Pleurisy
Pneumatic fever	Arthritis	Rubella	Parkinson's	HIV/AIDS

**Signature of Patient:** \_\_\_\_\_ **or Substitute Decision-Maker:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

Date of Last Update of Patient Health Summary: