

DR. LEILA SAHABI, N.D.

TRIBECA HEALTH GROUP

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ADULT PATIENT PROFILE

DATE _____

FULL NAME	_____	AGE _____	BIRTHDATE _____/_____/_____	MTH/DY/YR
ADDRESS	_____			PC _____
EMAIL	_____	How did you hear about us?		_____
HOME PHONE #	_____		WORK PHONE #	_____
CELL PHONE #	_____		PREFERRED CONTACT:	HOME/WORK/CELL
OCCUPATION	_____		EMPLOYER	_____
EMERGENCY CONTACT	_____		PHONE	_____
PRIMARY PHYSICIAN	_____		PHONE	_____
KNOWN ALLERGIES (FOOD, DRUGS, VACCINES, ENVIRONMENTAL ETC.)				

Note to patients: Please complete this two-sided questionnaire as thoroughly as possible in order to aid the physician in her diagnosis and treatment. This is a confidential record and will NOT be released unless you have authorized us to do so. Thank you

PRESENT HEALTH PROBLEMS CONCERNS: Please list in the order or priority to YOU

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

LIST OF MEDICATIONS CURRENTLY TAKING (prescription & over the counter drugs, vitamins, herbs, homeopathic remedies etc.)

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

PAST MEDICAL HISTORY

Hospitalization (when, for what, and for how long?)

ACCIDENTS & INJURIES

PSYCHIATRIC ILLNESSES

LAST COMPLETE PHYSICAL EXAM DATE: _____

DESCRIBE ANY ABNORMAL FINDINGS: _____ WERE THE RESULTS NORMAL ABNORMAL

LAST PAP SMEAR (WOMEN ONLY) DATE: _____ WERE THE RESULTS NORMAL ABNORMAL

DO YOU DO MONTHLY SELF EXAM? YES _____ NO _____

PERSONAL LIFESTYLE (CHECK AND FILL IN WHERE APPLICABLE)

HABITS:

TOBACCO YES _____ NO _____ HOW MANY YEARS? _____ HOW MANY CIGARETTES PER DAY? _____

CAFFEINE (COFFEE, TEA, POP) YES _____ NO _____ HOW MUCH DAILY? _____

ALCOHOL YES _____ NO _____ HOW MUCH? _____

RECREATIONAL DRUGS YES _____ NO _____ WHAT KIND? _____ HOW MUCH? _____

REGULAR EXERCISE YES _____ NO _____ WHAT KIND? _____ HOW OFTEN? _____

DIET: DESCRIBE YOUR AVERAGE DAILY MEALS

BREAKFAST: _____

LUNCH: _____

DINNER: _____

SNACKS: _____

LIST FOODS THAT YOUR CRAVE: _____

ARE THERE ANY DIET RESTRICTIONS OR REGIMENS THAT YOU FOLLOW? PLEASE DESCRIBE:

SLEEP

AVERAGE HOURS OF SLEEP PER NIGHT _____ DO YOU TAKE HERBS OR PILLS TO HELP YOU SLEEP? YES _____ NO _____

DO YOU HAVE DIFFICULTY SLEEPING? DAILY _____ OFTEN _____ SOMETIMES _____ NEVER _____

DO YOU DREAM? DAILY _____ OFTEN _____ SOMETIMES _____ NEVER _____

SOCIAL HISTORY

MARITAL STATUS SINGLE _____ MARRIED _____ SIGNIFICANT OTHER/Common Law _____ WIDOWED _____

SEXUALLY ACTIVE YES _____ NO _____ TYPE OF BIRTH CONTROL _____

HOW MANY CHILDREN? _____ AGES _____

FAMILY HISTORY: CHECK AND FILL IN APPLICABLE BOXES (BLOOD RELATIVES)

	WHO	COMMENTS
ALLERGIES		
ANEMIA		
ARTHRITIS		
AUTO IMMUNE		
ASTHMA		
CANCER		
DIABETES		
HEART DISEASE		
HEPATITIS		
HIGH BLOOD PRESSURE		
KIDNEY DISEASE		
MENTAL ILLNESS		
STROKE		
TUBERCULOSIS		
OTHER		