

Dr. Melissa Carr, B.Sc., Dr.TCM, R.Ac.
#410-2184 West Broadway, Vancouver, B.C.
604-783-2846

Today=s Date: day / month / year

 Dr. Mr. Mrs. Ms.

Name: _____ Birth date: _____

 day / mo / yr

Address: _____ City _____ Postal code _____

Tel: home _____ work/mobile _____ Email: _____

_____ Contact preference method: home tel. work/mobile

tel. email postal mail

Can I contact you periodically for check ups? yes no

Occupation: _____

How did you learn about Dr.Carr? _____

PERSONAL MEDICAL HISTORY

Reason for today=s visit: _____

Have you ever been treated with Traditional Chinese Medicine? yes no

Other current therapies _____

Who is your physician? _____ Telephone: _____

Surgeries: _____

Please list any pharmaceuticals you are currently taking _____

Please list any supplements you are currently taking _____

Are you pregnant? yes no

Do you have any allergies? _____

Please check any of the following that are significant to your medical history:

| | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High or Low Blood Pressure | |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Migraines | <input type="checkbox"/> TB |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Skin conditions | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | |

Lifestyle (please check those that apply and give frequency):

Alcohol _____ Tobacco _____ Drugs _____

Exercise type and frequency: _____

Are you interested in learning about an exercise program? yes no

Diet: Vegetarian Vegan Coffee Tea

Gynecology:

Age of first menses: _____ Length of cycle: _____ Menses duration: _____

Age of menopause: _____

Are you currently taking the birth control pill? yes no

Number of pregnancies? _____

 Irregular period Painful periods PMS Breast lumps

EMERGENCY CONTACT:

Name: _____ Telephone: _____

(Patient signature)

(Date)