

**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)