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Dr. Ross Davidson MD FRCPC, CSCN (d)

Specialists in Physical Medicine and Rehabilitation

Mr Mrs Ms Miss Dr (circle one)	Full Name: Birthdate: Address:		
Age _____	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Height: Weight:	Handedness: Right <input type="checkbox"/> Left <input type="checkbox"/> Ambidextrous <input type="checkbox"/>	
Description of Symptoms			
What is the <u>main</u> reason for your appointment today?			
In brief, please describe your symptoms (the main reason for today's appointment)			
How long have these symptoms been bothering you for?			
What treatments have you tried for this problem?			

Past Medical History

Please list your medical conditions

Do you have any history of abnormal blood sugar tests? (diabetes, prediabetes, impaired fasting blood sugar or gestational diabetes?)

Yes No

If yes, which type?

Do you have any history of thyroid problems diagnosed by a physician?

Yes No

If yes, which type?

Do you have any history of autoimmune disorders diagnosed by a physician? (This may include lupus, rheumatoid arthritis, sjogrens syndrome, spondyloarthritis, celiac disease, psoriasis, ulcerative colitis, chrohn's disease)

Yes No

If yes, which type?

Do you have any history of significant childhood medical illness?	
Do you have any history of mental health and/or substance abuse disorders? If yes, please specify	
Past Surgical History	
Please list your previous surgeries and the year in which the surgery occurred (if possible)	
Medication History	
Please list your current medications and supplements (use separate sheet, or attach a list if necessary)	
Do you have any allergies to medications?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Please list your allergies and indicate the reactions (hives, nausea, anaphylactic, etc)	

Social History		
Highest Level of Formal Education	0-8 years <input type="checkbox"/> 8- _____ 12 years <input type="checkbox"/> _____ Diploma <input type="checkbox"/> _____ Degree <input type="checkbox"/> _____ Specialized _____ Qualifications <input type="checkbox"/> _____	Work Status: Student <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> If yes, last job On Disability <input type="checkbox"/> worked: _____ Working <input type="checkbox"/> If indicated, place and/or type of work: _____
Behaviours that may affect health status		
Do you smoke cigarettes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	IF yes, how many per day?
Do you drink alcoholic beverages?	Yes <input type="checkbox"/> No <input type="checkbox"/>	IF yes, how many per week?
Do you have any recreational drug use?	Yes <input type="checkbox"/> No <input type="checkbox"/>	IF yes, which type and how often?
Family History (If family history is unknown, please indicate)		
Are you aware of any family history of neurological disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	IF yes, what is the diagnosis? What is their relation to you?
Are you aware of any family history of autoimmune disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	IF yes, what is the diagnosis? What is their relation to you?