How did you hear about us? (please circle one)
Family/Friend ☐ Internet ☐ Signage/Advertising ☐ Other: _____

Reviewed by Provider: _____
Scanned/Entered by: _____

HEALTH QUESTIONNAIRE

The purpose of this questionnaire is to ensure that your electronic medical record contains complete and up-to-date information so we can provide you with optimal comprehensive care. Please fill in the relevant sections to the best of your ability and give to your health care provider at your next visit. Strict confidentiality is ensured. Thank you.

Name (Last, First, M.I.):		**DOB:**
Previous Family Physician:	**City:**	**Last Seen:**

CURRENT MEDICAL HISTORY

List Current Conditions (please use back of page if you need more room)

Physical:	
Emotional & Social:	

List details of your prescription medications below (if unable to list, bring them with you to our clinic)

Prescription Medications – Name	Strength	Frequency Taken

List your non-prescription medications (over-the-counter drugs, vitamins, herbs, etc.)

List the details of allergies or side effects to medications below

Name of Medication	Reaction You Had

PAST MEDICAL HISTORY

Childhood Illness: Have you ever had **chickenpox?** ☐ Yes ☐ No*

Immunizations: (include dates)

☐ **Tetanus** within past 10 years	☐ **Pneumonia**
☐ **Chickenpox***	☐ **Hepatitis** (circle type): ☐ A ☐ B ☐ Both ☐ Unsure

Operations/ Procedures

Type of Operation or Procedure	Reason	Year

Other Hospitalizations

Name of Hospital	Reason	Year

Other Major Past Problems/Injuries

Description of Problem or Injury	Outcome	Year

Obstetrical History (indicate number if any)

Total Pregnancies:	**Term Deliveries:**	**Preterm Deliveries:**
Miscarriages:	**Pregnancy Terminations:**	**Living:**
Obstetrical Complications:		

Current Date: _____

Physician's Initials: _____

Patient Name: _____ DOB: _____

FAMILY MEDICAL HISTORY

Please indicate relationship and approx age of onset for blood relatives with any of the following conditions

Disease	Relationship & Approximate Age of Onset
Heart Disease	
High Cholesterol	
Diabetes	
Asthma	
Stroke	
Dementia/Alzheimer's	
Osteoporosis	
Psychiatric Problem	
Cancer (indicate type)	

SOCIAL HISTORY

Marital Status: ☐ Never Married ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed

Occupation: ☐ Student ☐ Retired ☐ Disability ☐ Social Assistance

Recreation/Hobbies:

Religion:

Lifestyle	**Circle what best describes your diet:**	VERY POOR	POOR	FAIR	GOOD	EXCELLENT	
	Circle what best describes your activity level:	MINIMAL	POOR	FAIR	GOOD	EXCELLENT	
Tobacco	**Circle your smoking status:**	NEVER SMOKED	SMOKER	EX-SMOKER	PASSIVE SMOKE CONTACT		
	Cigarettes - #/day:			**Year Stopped:**			
Alcohol	**Circle what best describes your drinking habits:**	NONE	LIGHT	MODERATE	HEAVY	EX-DRINKER	
	How many drinks per day on average:			**Year Stopped:**			
	Are you concerned about the amount you drink?				☐ Yes	☐ No	
	Have you considered cutting down?				☐ Yes	☐ No	
	Are you prone to "binge" drinking?				☐ Yes	☐ No	
	Have you ever had a problem with alcohol?				☐ Yes	☐ No	
Street Drugs	**Circle what best describes your recreational drug use:**	NEVER	EX-USER	LIGHT	MODERATE	HEAVY	
	If yes, have you ever given yourself street drugs with a needle?				☐ Yes	☐ No	
	What drugs have you used?						
	How often do you usually use?			**Date last used?**			
Sex	**Have you ever had sex?**				☐ Yes	☐ No	
	Are you sexually active now?				☐ Yes	☐ No	
	If yes, what contraceptive method do you use, if any?						
	Do you have any problems with infertility?				☐ Yes	☐ No	
	Circle your sexual orientation:	HETEROSEXUAL	BISEXUAL	HOMOSEXUAL	UNKNOWN		

PREVENTION AND WELLNESS

Preventive Screening Tests (please give approximate dates for the following)

Women Only	(<70) **Date of last pap** (recommended every 1-2 years):
	(>50) **Date of last mammogram** (recommended every 1-2 years):
Both	(>50) **Date of last stool test for colon cancer** (recommended once a year):
	Date of last cholesterol test:

Personal Health Goals

What areas of your life would you like to make changes in?

What changes have you made/are you making so far?

What help would you like?