HEALTH HISTORY QUESTIONNAIRE
All information is confidential and will become part of your medical record.

Name: *(Last, First)*	**DOB:** *(yyyy/mm/dd)*
Gender:	**Health Card#:**
Address:	**Cell:** **Home:**
Preferred Pharmacy Address:	**Tel:** **Fax:**
Email Address: *(Please see email policy)*	
Permission to leave voicemail/send email regarding test results, etc: ☐ Yes ☐ No	
Emergency Contact: *Relationship:*	**Tel:**
Marital Status: ☐ Single ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed	

Place of Birth:	**If not Canada, when did you immigrate?**
Education:	**Occupation**:

PERSONAL HEALTH HISTORY

Immunizations and Dates:	☐ Tetanus:	☐ Chicken Pox:
	☐ Diphtheria:	☐ Hepatitis A:
	☐ Polio:	☐ Hepatitis B:
	☐ Pertussis:	☐ Meningitis:
	☐ Hib:	☐ HPV:
	☐ Pneumonia:	☐ Influenza:
	☐ Rotavirus:	☐ Shingles:
	☐ Meningitis:	☐ Other:
	☐ MMR:	☐ Other:

List any MEDICAL PROBLEMS diagnosed by a doctor:

1)_____
2)_____
3)_____
4)_____
5)_____

List any HOSPITALIZATIONS (include year):

1)_____
2)_____
3)_____
4)_____

List any SURGERIES (include year):

1)_____
2)_____
3)_____
4)_____

Have you ever had a blood transfusion? ☐ Yes ☐ No

Current Medications (prescription and non-prescription *(vitamins, herbal, etc.)***)**

Drug	Dose	Frequency

Allergies to Medications

Drug	Reaction

Preventive Care Testing
(Note: These tests are recommended for screening after a specific age)

Test	Date	Result
Colonoscopy		
FOBT/Stool Test		
Bone Mineral Density		
Mammogram		
Pap smear		
PSA		

HEALTH HABITS AND PERSONAL SAFETY

Exercise	Do you engage in regular physical activity?		☐ Yes		☐ No
		If yes, what form?		How often?	
Diet		Please outline any dietary restriction:			
Alcohol	Do you drink alcohol? If yes, what kind?		☐ Yes		☐ No
		How many drinks per sitting?		Drinks/week?	
Tobacco	Do you use tobacco?	☐ No - Quit Date:	☐ Yes		☐ Never
		Cigarettes: _____ packs/day Pipe: _____/day	Chew: _____/day Cigars: _____/day		
Drugs	Do you currently use recreational drugs?		☐ Yes		☐ No
		If so, which drugs?			
	Have you ever given yourself drugs with a needle?		☐ Yes		☐ No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			**Children** ☐M ☐F		
Mother			☐M ☐F		
Sibling ☐M ☐F			☐M ☐F		
☐M ☐F			☐M ☐F		
☐M ☐F			**Other**		
☐M ☐F					