

HEALTH HISTORY QUESTIONNAIRE

Name: <i>(Last, First)</i>		DOB: <i>(yyyy/mm/dd)</i>	
Gender:		Health Card#:	
Address:		Cell:	
		Home:	
Preferred Pharmacy Address:		Tel:	
		Fax:	
Email Address: <i>(Please see email policy)</i>			
Permission to leave voicemail/send email regarding test results, etc: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency Contact: <i>Relationship:</i>			Tel:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Place of Birth:		If not Canada, when did you immigrate?	
Education:		Occupation:	
Referred By: <input type="checkbox"/> HCC <input type="checkbox"/> Other (Specify)			

PERSONAL HEALTH HISTORY

Immunizations and Dates:	<input type="checkbox"/> Tetanus:	<input type="checkbox"/> Chicken Pox:
	<input type="checkbox"/> Diphtheria:	<input type="checkbox"/> Hepatitis A:
	<input type="checkbox"/> Polio:	<input type="checkbox"/> Hepatitis B:
	<input type="checkbox"/> Pertussis:	<input type="checkbox"/> Meningitis:
	<input type="checkbox"/> Hib:	<input type="checkbox"/> HPV:
	<input type="checkbox"/> Pneumonia:	<input type="checkbox"/> Influenza:
	<input type="checkbox"/> Rotavirus:	<input type="checkbox"/> Shingles:
	<input type="checkbox"/> Meningitis:	<input type="checkbox"/> Other:
	<input type="checkbox"/> MMR:	<input type="checkbox"/> Other:

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

List any MEDICAL PROBLEMS diagnosed by a doctor:

- 1) _____
- 2) _____
- 3) _____

List any HOSPITALIZATIONS (include year):

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

List any SURGERIES (include year):

- 1) _____
- 2) _____
- 3) _____

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

PREVENTITIVE 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what form?	How often?	
Diet	Please outline any dietary restriction:		
Alcohol	If you drink alcohol, what kind?		
	How many drinks per sitting?	Drinks/week?	
Tobacco	Do you use tobacco?	<input type="checkbox"/> No - Quit Date (DD-MM-YY):	<input type="checkbox"/> Yes <input type="checkbox"/> Never
	Cigarettes: ___ packs/day Chew: ___/day Pipe: ___/day Cigars: ___/day		
Drugs	Do you currently use recreational drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If so, which drugs?		
	Have you ever taken drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children <input type="checkbox"/> M <input type="checkbox"/> F		
Mother			<input type="checkbox"/> M <input type="checkbox"/> F		
Sibling <input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F		
<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F		
<input type="checkbox"/> M <input type="checkbox"/> F			Other		
<input type="checkbox"/> M <input type="checkbox"/> F					

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