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#:**
Name Of Mother: *(Or Primary Caregiver/Guardian)*		**Tel:**
Name Of Father: *(Or Primary Caregiver/Guardian)*		**Tel:**
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:**
Place of Birth:	**If not Canada, when did you immigrate?**	
School:	**Grade**:	

PERSONAL HEALTH HISTORY

Childhood Illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Rheumatic Fever ☐ Polio	
Immunizations and Dates:	☐ Tetanus:	☐ Chicken Pox:
	☐ Diphtheria:	☐ Hepatitis A:
	☐ Polio:	☐ Hepatitis B:
	☐ Pertussis:	☐ Meningitis:
	☐ Hib:	☐ HPV:
	☐ Pneumonia:	☐ Influenza:
	☐ Rotavirus:	☐ Shingles:
	☐ Meningitis:	☐ Other:
	☐ MMR:	☐ Other:

Birth History

Born at:	☐ Term *(37-40 weeks)*	☐ Pre-Term: _______ *weeks*
Conception:	☐ Natural conception	☐ Assisted reproduction
	☐ Adopted	
Pregnancy:	☐ No Complications	☐ Gestational Diabetes
	☐ Maternal Infections (*Including Group B Strep)*	☐ Maternal fever during delivery treatment
	☐ Other:	
Delivery:	☐ Normal vaginal delivery	☐ Caesarian section
	☐ Vaginal delivery with complications	☐ Resuscitation required
	☐ Birth injury	☐ 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

Have there been any developmental concerns?

____
____
____
____
____

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

Drug	Dose	Frequency

Allergies to Medications

Drug	Reaction

HEALTH HABITS AND PERSONAL SAFETY

Exercise	
Dietary Restrictions	
Hobbies	

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Grandmother (Maternal)		
Mother			Grandfather (Maternal)		
Sibling ☐M ☐F			Grandmother (Maternal)		
☐M ☐F			Grandfather (Maternal)		
☐M ☐F					
☐M ☐F					

This Health History Questionnaire was completed by

Name:

Relationship to patient:

Date: