COMPREHENSIVE MEDICAL QUESTIONAIRE

Please do not complete this form if you have a family physician as we are only taking patients without a family physician

SURNAME:	FIRST NAME:
[redacted] HEALTH CARE NUMBER: [redacted] - -	DATE OF BIRTH:
HOME ADDRESS:	PROVINCE: POSTAL CODE:
PRIMARY PHONE #	ALTERNATE PHONE #
E-MAIL ADDRESS	PREVIOUS FAMILY PHYSICIAN:

CURRENT HEALTH CONCERNS

(Please list any significant medical problems that you are currently concerned about)

Problem	Date of Onset	Comments
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		

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MEDICATIONS AND ALLERGIES –

(PLEASE NOTE – THE DOCTORS AT THIS OFFICE DO NOT PRESCRIBE NARCOTIC MEDICATIONS TO NEW PATIENTS)

(Please list your current medications and allergies to medications)

Medication	Dosage	Comments

Medication Allergy (list all)	Nature of Allergic Response When Taken

OTHER ALLERGIES AND IMMUNIZATIONS

			Comments
Do you have any allergy problems?	Yes	No	
Do you have hay fever symptoms?	Yes	No	
Do you have food allergies?	Yes	No	
Have you had a tetanus shot?	Yes	No	Date:
Do you get an annual flu vaccine?	Yes	No	
Have you had a pneumonia vaccine?	Yes	No	
Have you had a polio immunization series?	Yes	No	
Have you had recent immunizations?	Yes	No	List:
Have you had a tuberculosis skin test? (Mantoux Test)	Yes	No	Date: Result: Positive ☐ Negative ☐

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SIGNIFICANT PAST HISTORY

(Please list any significant illnesses, including hospitalizations, you have had in the past)

Illness	Year	Comments
Hospitalization	Year	Hospital and City
Surgery	Year	Hospital and City

OTHER SIGNIFICANT TREATMENTS

(Please list any other significant treatments you have received such as radiation, chemotherapy, or other)

Treatment	Year	Comment

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SIGNIFICANT **FAMILY** HISTORY

(Please list any family history you have regarding the following conditions)

Health Problem	Yes	No	Comments
Diabetes Mellitus	☐	☐	
High Blood Pressure (Especially under age 50)	☐	☐	
Stroke (Especially under age 50)	☐	☐	
Heart Attack (Especially under age 50)	☐	☐	
Heart Surgery or Bypass (Especially under age 50)	☐	☐	
Breast Cancer	☐	☐	
Colon Cancer	☐	☐	
Lung Cancer	☐	☐	
Prostate Cancer	☐	☐	
Other Cancers	☐	☐	
Arthritis or Joint Replacement	☐	☐	
Back Pain	☐	☐	
Sudden Death	☐	☐	
Thyroid Disease	☐	☐	
Osteoporosis	☐	☐	
Obesity	☐	☐	
Other Diseases	☐	☐	

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SIGNIFICANT PERSONAL HABITS

(Please complete the following information on your personal habits and health risks)

TOBACCO	Yes	No	Comment
Did you live with people who smoke?			
Did your Parents smoke?			Father __ ☐ Mother__ ☐
Have you **ever** used tobacco?			
Do you **currently** use tobacco?			
Cigarettes			Amount
Cigars			Amount
Pipe			Amount
Smokeless Tobacco			Amount

ALCOHOL	Yes	No	Comment
Do you drink alcoholic beverages?			
Beer?			Amount Per week?
Wine?			Amount Per week?
Hard Liquor / Spirits?			Amount Per week?
Did you used to drink alcohol?			
Have you ever considered alcohol to be a personal problem?			
Have you ever felt you should cut down on your drinking?			
Have people ever annoyed you by criticizing your drinking?			
Have you ever used alcohol to get over a hangover?			
Has drinking ever affected your job?			
Have you ever driven your vehicle when you know you are intoxicated?			
Have you ever been charged with driving while intoxicated?			

OTHER COMMENTS

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DIETARY HABITS

(Please enter the following information regarding your diet)

Question	Yes	No	Comment
Are you comfortable with your weight?			Why?
Have you been losing weight?			Amount?
Would you like to lose weight?			Amount?
Do you have an ideal weight for you?			Amount?
Have you tried to diet in the past?			Which diets?
Do you have any dietary restrictions?			What?
Do you eat 3 meals a day?			If No, Then How Many?
	Yes	No	
Do you drink coffee?			If Yes How Much?
Do you drink caffeinated teas?			If Yes How Much?
Do you drink caffeinated colas or soda?			If Yes How Much?
Do you drink diet colas or soda?			If Yes How Much?
Do you drink milk?			If Yes How Much? What type? Skim 1% 2% Whole
Do you drink water?			How much? What type? Tap Distilled Bottle
Do you take dietary supplements, vitamins or minerals?	☐	☐	Please list all that you take.

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ACTIVITY LEVEL

(Please enter the following information regarding your level of physical activity)

Circle below the level of physical activity that you think you have in comparison to others your same age and sex

Sedentary	Mild Activity	Average Activity	Quite Active	Very Active

Please answer the following questions

	Yes	No	Comment
Are you on an exercise program?			
Are you consistent with your program?			
Do you enjoy exercise?			
Do you have any musculoskeletal concerns, restrictions or disabilities?			

If you exercise, please provide the following information regarding safety when you exercise.

	Yes	No	Comment
Do you warm up before exercise?			
Do you cool down after exercise?			
Do you know how to take your pulse?			
Do you monitor your heart rate?			
Do you wear protective equipment when necessary?			

SLEEPING HABITS

(Please answer the following questions about your sleep)	Never	Sometimes	Always
Do you sleep enough hours each day?			
Are you rested?			
Do you have to use an alarm to wake up?			
Do you have to catch up on your sleep?			
Do you ever wish you could nap after lunch?			
	Back	Side	Stomach
Please indicate your usual sleeping posture (s)			

	Yes	No	
Do you sleep with a pillow			
Do you use a special type of pillow?			Type?

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WOMENS HEALTH CONCERNS

(Please complete the following information)

Number of Pregnancies	Number of Children	Number of Lost Pregnancies

Date of Last Menstrual Period?	Date of Last Pelvic Examination?
Date of Last PAP Test?	Date of Last Breast Examination?
Date of Last Mammography?	

	Yes	No	Comments
Have you had a hysterectomy?			When?
Have you had any other gynecological (female) surgery?			What?
Have you had an abnormal pelvic exam?			
Have you had an abnormal PAP test?			
Are your periods abnormal?			
Do you have urine loss when you cough sneeze or laugh?			
Are you currently using birth control?			Type?
Have you been pregnant?			Number Of times?
	Yes	No	Comments
Do you experience any premenstrual tension or depression?			
Do you do breast self-examination each month?			Which Day Of The Month?
Are you aware of any breast lumps?			
Do you have any nipple discharge or abnormal bleeding?			
Have you ever had a breast biopsy?			
Have you had any other breast surgery?			What?

Please list any other current concerns you may have regarding your female health.

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STRESS AND EMOTIONAL FACTORS

(Please answer the following questions as carefully as you can)

	Yes	No	Comments
Do you consider your home life stressful?			
Do you consider your work life stressful?			
Are you married?			How Many Years?
Do you have children?			How Many? Ages?
Do you consider yourself a tense or anxious person?			
Do you feel you manage stress well?			
Are you taking any medications for emotional or mental health concerns? (Please list the medication and what you take the medication for.)			Medication:_____ Taken For:_____ Medication:_____ Taken For:_____ Medication:_____ Taken For:
Have you ever been in counseling with a counselor, psychologist or psychiatrist?			Why?
Are you currently seeing a counselor, psychologist or psychiatrist?			Why? Who?

Please circle the area of your greatest **current** concern or worry.

Marriage	Family	Work	Finances	Health	Other

Briefly describe your **current** concern or worry

Please **list** any significant or traumatic life events. Significant/traumatic life events may include family of origin or immediate family concerns such as drug/alcoholism, divorce/separation/death, or abuse (physical, emotional, sexual). It may also include significant conditions such bouts of mental illness, physical disability or genetic disorders.

1.
2.
3.

Identify your position in your family of origin (e.g., are you a first born or second born, or only child?).

Only Child ☐	First Born ☐	Second Born ☐	Third Born ☐	Fourth Born ☐	(_____) Born