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:	
Active ICBC/WSBC Claims:	Yes ☐ or No ☐

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

Prescription Medications – Name	Strength	Frequency Taken

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

List the details of allergies or side effects to medications below

Name of Medication	Reaction You Had

Please turn to next page

PAST MEDICAL HISTORY

Immunizations (Circle Types if Known)

☐ Shingles: zostavax shingrix ☐ Hepatitis: A B ☐ Pneumonia: prevnar pneumovax

☐ Tetanus (within the last 10 yrs) ☐ Influenza ☐ Covid-19 ☐ Other: _____

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:

FAMILY MEDICAL HISTORY

Please indicate relationship and approximate 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)	
Other	

Please turn to next page

SOCIAL HISTORY

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

Occupation (or 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*	MOD* 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 OTHER

PREVENTION AND WELLNESS

Preventive Screening Tests (Please give approximate dates for the following)*

Women only	(<70)	Date of last pap (recommended every 3 years)
	(>50)	Date of last mammogram (recommended every 2 years)
Both	(>50)	Date of last stool test for colon cancer (recommended every 2 years)
		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?