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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 it to your healthcare provider. Strict confidentiality is ensured. Thank you.

Name *(Last, First, M.I.):* **Birthday :Phone:**

Address: **Email:**

Alberta Health Care Number and Emergency Contact Name and Number:

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:	

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
Pharmacy Name:		

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**	
PAST MEDICAL HISTORY		
Childhood Illness:	Have you ever had chickenpox? ◞ Yes or ◞ No*	
Immunizations: (Please include dates) **Operations/Procedures** Type of Operation or Procedure	◞ Tetanus within past 10 years ◞ Pneumonia ◞ Chickenpox* ◞ Hepatitis (Circle Type: A B Both Unsure) 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	
Hypertension (High Blood Pressure)	
Diabetes	
Asthma	
Stroke	
Dementia/Alzheimer's	
Osteoporosis Psychiatric problem Cancer (indicate type) Other	
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 SMOKER 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 Circle what best describes your recreational drug use: NEVER EX_USER LIGHT* MOD* HEAVY* **Drugs**

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 it? Date last used?

Sex Have you 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

PREVENTION AND WELLNESS

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

Women only (<70) (>50**)**	Date of last pap (recommended every 3 years if previously normal): Date of last mammogram (recommended every 1 or 2 years):

Both (>50) Date of last stool test for colon cancer (recommended once a year): 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?