CLINIC AT THE CORNER
EST. 2019

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Thanks for letting us get to know you! In order for your new family physician to provide the best care for you, it would be helpful for them to know a bit more about your previous health history, your lifestyle and your current medical concerns.

Please complete the following questionnaire and drop it off at the office 1-2 days prior to your initial appointment. Your physician can review your responses in advance and therefore make the most of your first visit to go over your current health status.

Please be advised that your initial appointment will likely be completely dedicated to reviewing the information below and ensuring your prescriptions, bloodwork and other testing is up to date. You and your physician can then make a plan going forward to address any new medical concerns at future appointments.

Demographic information

Full name _____

Birthdate _____

Age _____

Sex _____

Current address _____

_____

_____

Health card number _____

Ethnicity _____

Languages spoken _____

Social information

Marital status single / married / common-law / divorced / widowed

Name of partner, if applicable _____

What are the names of your children, if any?

_____

With whom do you live? _____

_____

_____

What is your highest level of education? (eg. High school, Master's degree, etc.)

_____

Please list your occupation (current, and previous)

_____

_____

_____

_____

_____

_____

Do you have private insurance for physiotherapy, massage, etc.? Yes No

If you wish to disclose, do you have insurance through aboriginal status? Yes No

Who is your Power of Attorney for Personal Care?

_____

Who is your Power of Attorney for Finances?

_____

Current medications

Medication name	*Dose*	*Frequency*	*Why do you take this?*
eg. Perindopril	4mg	twice a day	blood pressure

Over the counter medications

Please list any over the counter medications, supplements or herbal remedies that you take.

Allergies

Please list any allergies you have, as well as your reaction.

Previous medical issues

Please list any medical conditions for which you have seen a doctor.
If you needed treatments like medications or surgery, please list that.
If you are currently seeing a specialist for a medical issue, please list that as well.

Previous mental health concerns

Please list any current or previous concerns about your mental health and any treatments (therapy, medication, etc.).

Previous surgeries

Please list any surgeries , the approximate year, and the surgeon if you remember.

Lifestyle information

Have you ever smoked? Yes No

If yes, for how many years did you smoke? How many packs per day? When did you quit?

How many alcoholic drinks do you have in a typical week?

Do you use cannabis for medical / recreational purposes?

Do you, or have you ever, used other recreational drugs?

Have you ever struggled to control the amount of alcohol, marijuana or drugs you use?

Do you exercise? How many times per week? How long per session?

How much caffeine do you drink in an average day?

Home services and supports

Do you currently receive any services at home such as Meals on Wheels, home nursing, personal support workers, etc.? Please list:

_____

_____

_____

_____

Do you currently use a gait aid, such as a walker, cane, or wheelchair? _____

Do you currently drive? _____

Preventative health review

Please indicate, as best you remember, when you last had the following tests.
Please write down if they were ever abnormal.

Eye exam _____

Hearing test _____

Pap smear _____

STI testing _____

Mammogram _____

Colonoscopy _____

Stool testing for colon cancer _____

Bone density (osteoporosis) _____

Tetanus vaccine _____

Pneumonia vaccine _____

Shingles vaccine _____

Routine bloodwork _____

Family history

Condition	*Family member (eg. Mother)*	*Age at diagnosis*
Diabetes		
High blood pressure		
Heart attack		
Stroke		
Other heart disease		
Breast cancer		
Colon cancer		
Ovarian cancer		
Uterine cancer		
Other cancer		
Osteoporosis		
Broken hip		
Dementia / Alzheimer's		
Mental health		
Addiction		