Original Date:
Dates Revised:

NEW PATIENT HEALTH QUESTIONNAIRE

Name (Last, First):						**DOB:**
Sex (genetically) **M F**	**Preferred Pronoun**					
Marital status:	Single	Partnered/Married	Divorced	Widowed	**Spouse's Name:**	
Address:						
Phone numbers: (personal)	(work)				**Email:**	
Occupation:						
Preferred Appointment Confirmation Method:						

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed		
Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	Yes	No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	Sedentary (No exercise)				
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Do you have any food intolerances?			Yes	No
	Are you vegetarian?			Yes	No
	What type?				
Caffeine	☐ None	Coffee	Tea	Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			Yes	No
	If yes, what kind?				
	How many drinks per week?				
	In the last year, have you ever drank more than you intended to?			Yes	No
	Have you considered stopping?			Yes	No
	Have you ever experienced blackouts?			Yes	No
Tobacco	Do you use tobacco?			Yes	No
	Cigarettes – pks./day	Chew - #/day	Pipe - #/day	Cigars - #/day	
	# of years	Or year quit			
Drugs	Do you currently use recreational or street drugs?			Yes	No
	Have you ever given yourself street drugs with a needle?			Yes	No
Personal Safety	Do you live alone?			Yes	No
	Do you have frequent falls?			Yes	No

	Do you have vision or hearing loss?	Yes	No
	Do you have an Advance Directive and/or Living Will?	Yes	No
	Would you like information on the preparation of these?	Yes	No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	Yes	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	M F	
Mother				M F	
Sibling	M F			M F	
	M F			M F	
	M F		**Grandmother** Maternal		
	M F		**Grandfather** Maternal		
	M F		**Grandmother** Paternal		
	M F		**Grandfather** Paternal		

MENTAL HEALTH

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Have you ever been to a counselor?	Yes	No

WOMEN ONLY		

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	Yes	No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	Yes	No
Have you had a D&C, hysterectomy, or Cesarean?	Yes	No
Any blood in your urine?	Yes	No
Any hot flashes or sweating at night?	Yes	No
Date of last pap and rectal exam?		

MEN ONLY		

Do you usually get up to urinate during the night?	Yes	No
If yes, # of times		
Do you feel pain or burning with urination?	Yes	No
Any blood in your urine?	Yes	No
Do you feel burning discharge from penis?	Yes	No
Has the force of your urination decreased?	Yes	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes	No
Do you have any problems emptying your bladder completely?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Any testicle pain or swelling?	Yes	No

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Once completed, please return to admin@salutefamilymedicine.ca or drop off at the office. One of our team members will call you to book an appointment.