ONE HEALTH
MEDICAL CENTER

**Meet and Greet Questionnaire**

First name:_____ Last name:_____
Health card number: _____ Expiry date (mm/dd/yyyy): _____
Birthdate (mm/dd/yyyy): _____ Home phone: (_____) _____ - _____
Work phone: (_____) _____ - _____ Cell phone: (_____) _____-_____
Email address:_____
Address: _____
City: _____ Postal Code: _____
Emergency Contact name:_____ Phone: _____ Relation: _____

**Preferred Pharmacy**

Would you like Oakville Pharmacy located across from our Clinic to be your pharmacy? Y / N
If you selected no, please fill in your pharmacy information below:
Pharmacy location: _____ Phone #: (____) _____ - _____
Pharmacy Address: _____

Do you currently have a Family physician? **Y / N**
If yes, name of the physician _____ Clinic name: _____
Reason for switching family practice: _____

**Medical History**

*Indicate if you have/had any of the following medical problems.* **Y / N**

| | | | |
|---|---|---|---|
| Coronary Artery Disease | | Heart Attack/Bypass/CABG | |
| High Blood Pressure | | High Cholesterol | |
| Stroke / TIA | | Migraine | |
| Asthma | | COPD/Emphysema | |
| Diabetes | | Thyroid | |
| Liver Disease; Hep A/B/C | | Cirrhosis Gastrointestinal Disorders | |
| Kidney / Bladder Infection | | Osteoporosis | |
| Arthritis | | Chronic Muscle Joint Pain | |
| Anemia | | Clotting / Bleeding Disorder | |
| Anxiety | | Depression | |
| Ear / Nose / Throat problem | | Last FIT Date | |

| | | |
|---|---|---|
| Last Colonoscopy Date | | Have you ever been diagnosed with Cancer? **Y / N** |
| Type & Treatment: | | |

**Allergies**
* Do you currently have any allergies? **Y / N**
If yes, list the allergies _____

**Family History**
*List all family members and illnesses. If deceased, indicate at what age and cause of death* Mother _____ Father _____
Brother _____
Sister _____

**Life Style**
Do you smoke? **Y / N** How many per day? _____ Age started _____
# of years _____Quit? _____ Date: _____
Interested in Quitting? _____
Do you drink alcohol? **Y / N** If yes, consumption amount _____
Do you exercise? **Y / N** Describe _____

**For women:**
Number of pregnancies _____ Number of children _____
Age started menstruation _____ Age of menopause _____
Uterine disorder _____
Last PAP Date _____ Last Mammogram Date _____

**For men:**
Prostate disorder _____
Testicular disorder _____

**Employment Status:**
Employment: _____ Job title_____
Extended health benefit plan: _____

**Medications (Please list them)** Can we contact your pharmacist for your updated medication history? **Y / N**

| **Name of prescription** | **Dosage** | **Frequency** |
|---|---|---|
| | | |
| | | |
| | | |

If more medication then please ask for an additional sheet.

**One Health Medical Center**
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