Meadowbrook Family Practice

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 return the form to your health care provider at your next visit. Strict confidentiality is ensured. Thank you.

Name (Last, First):	Date of Birth:
Previous Family Physician's Name:	Last Seen
Sex at Birth: ☐ M ☐ F	Gender:

CURRENT MEDICAL CONDITIONS	
Physical Health Diagnoses	**Mental Health Diagnoses**
☐ Diabetes	☐ Depression
☐ Hypertension	☐ Anxiety
☐ COPD	Others:
☐ Previous heart attack	
☐ Cancer (type:)	
Others:	
Active ICBC/WSBC Claim(s): ☐ Yes ☐ No	
If YES, describe:	

PRESCRIPTION MEDICATIONS			
Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:
Name:	Dose:	Name:	Dose:
List any non-prescription drugs (e.g. over-the-counter medication, vitamins, herbs, etc)			
List any allergies or side-effects you have had to medications below			
Name of Medication	Reaction You Had		

PAST MEDICAL HISTORY		
Immunizations (Check if known)		
☐ Shingles	☐ Hepatitis A	☐ Pneumonia Pneumovax (65yo, free)
☐ Tetanus (last 10 years)	☐ Hepatitis B	☐ Pneumonia Prevnar (65yo, paid)

Operations, Procedures, & Surgeries		
Name:	Reason:	Year:
Name:	Reason:	Year:
Name:	Reason:	Year:
Name:	Reason:	Year:
Name:	Reason:	Year:
Name:	Reason:	Year:

Hospitalizations		
Hospital:	Reason:	Year:
Hospital:	Reason:	Year:
Hospital:	Reason:	Year:
Hospital:	Reason:	Year:

Obstetrical History		
Total Pregnancies:	Term Deliveries:	Preterm Deliveries:
Miscarriages:	Pregnancy Terminations:	Living children:
Obstetrical Complications: ☐ Gestational Diabetes ☐ Hypertension ☐ Other:		

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	

SOCIAL HISTORY							
Marital Status: ☐ Single ☐ Dating ☐ Common Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed							
Occupation: *or* ☐ Student ☐ Retired ☐ Disability ☐ Social Assistance							
Recreation & Hobbies:							
Religion:							
Lifestyle	Diet	☐ Very Poor	☐ Poor	☐ Fair	☐ Good	☐ Excellent	
	Activity	☐ Very Poor	☐ Poor	☐ Fair	☐ Good	☐ Excellent	
Tobacco	Smoking Status	☐ Never Smoked	☐ Smoker	☐ Ex-Smoker	☐ Passive Smoke Contact		
	Smoking Details	Cigarettes per day:	If "ex-smoker", what year did you quit?:				
Alcohol	Number of drinks per week:						
	Are you concerned about the amount you drink?	☐ Yes	☐ No				
	Have you considered reducing the amount you drink?	☐ Yes	☐ No				
	Are you prone to "binge" drinking?	☐ Yes	☐ No				
	Have you ever had a problem with alcohol?	☐ Yes	☐ No				
Other substances	Marijuana Use	☐ Never	☐ Ex-User	☐ Occasionally	☐ Weekly	☐ Daily	
	Vaping	☐ Never	☐ Ex-User	☐ Occasionally	☐ Weekly	☐ Daily	
	What other drugs do you use?						
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No				
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)?						
	Circle your sexual orientation: Heterosexual ☐ Bisexual ☐ Homosexual ☐ Unknown ☐ Other:						

PREVENTION AND WELLNESS				
Preventative Screening Tests (Please give approximate dates for the following)*				
Women 25 -70	Cervical cancer screen:	☐ Pap test in office	☐ HPV home testing	Year:
Women > 50	Breast cancer screening:	☐ Mammogram		Year:
All > 50	Colon cancer screening:	☐ Stool test	☐ Colonoscopy	Year:
All > 65	Osteoporosis:	☐ Bone density test		Year:

PERSONAL HEALTH GOALS
In what areas of your life would you like to make changes?
What changes have you made/are you making so far?
What help would you like?