New Patient Questionnaire

Surname __________________________ First Name _________________________ M _____ F ______

Preferred Name: __________________________ Email Address: _______________________________

Personal Health No:__________________ Prov. of Healthcare ________ Date of Birth ______________

Address _______________________________ City __________________ Postal Code _____________

Cell __________________________ Home ________________________(please circle most perferred)

Emergency Contact ___________________ Phone __________________ Relationship ______________

Preferred Pharmacy ____

Allergies to Medications: Yes _________ No __________ (if yes, please list and include reaction)

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Current Medications (prescription and non-prescription) _______________________________________

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Medical History or Current Medical Probelms (include surgeries and dates where possible)

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Ongoing Health Concerns as a result of a motor vehicle accident (ICBC): Yes _________ No __________

Ongoing Health Concerns as a result of a work related injury (Worksafe): Yes _________ No _________

Number of Pregnancies: Vaginal _______ Caesarians _______ Abortions _______ Miscarriages _______

Total Pregnancies ______ Height _______ Weight _______ When did you last smoke _______________

Cigarettes/day ___________ Cannabis _____________ Alcohol (number of drinks/week) ____________

IV Drugs ___________________ Other substances ____

Specialists invovled in your regular care ____

Family History: state relationship (Mother/Father, Brother/Sister, Grandmother/Grandfather) and age of diagnosis

Diabetes ________________________________ Heart Attack __________________________________

Depression ______________________ Cancer (include type) ___________________________________

Thyroid Disease _____________________________ Lung Disease ______________________________

Stroke _________________________________ High Cholesterol ______________________________

Eye Problems __________________________ Drugs/Alcohol Addiction ________________________

High Blood Pressure _______________________ Other _____________________________________

Patient Signature ____ Date ________________________