Health Information Form

Please complete your medical profile precisely

Surname:		First:	
Address:		City	Postal
DOB: YY/MM/DD	Sex:	Health Card # Version code (Two letters) :	
Profession:	Do you speak English?	Preferred language?	
Did you have a family Doctor before ?		Name of Doctor:	

**************SOCIAL HABITS************

Smoker ☐ Non-Smoker ☐	Have you ever smoked: Yes ☐ No ☐	How many per day?
Do you drink alcohol? Yes ☐ No ☐	How much?	How often?
Do you use recreational drugs? (can be left blank to discuss with physician) Yes ☐ No ☐ Type?		How often?
Do you have any allergies Yes ☐ No ☐ if so, list your allergies:		
Past medical problems/surgeries		
Family History (eg. Diabetes , Hypertension , cancer , etc)		

Preventative Care (If applicable)

Last Annual Physical:	Last Pap test:	Last Mammogram:
Last Colon Cancer Screen:	Last Eye exam:	Last Bone Density:
Last Tetanus shot:	Please bring immunization record to your appointment	

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Present medical problems			
Irregular Heart Rhythm ☐	Heart Murmur ☐	Depression ☐	Heart Disease ☐
Previous heart attack ☐	Angina/Chest pain ☐	Stroke ☐	High blood pressure ☐
Black out/Fainting spell ☐	Migraine/Headaches ☐	Glaucoma ☐	Anxiety ☐
Blood clots/Phlebitis ☐	Fibromyalgia ☐	Diabetes ☐	Emphysema or COPD ☐
Hiatus Hernia/Reflux ☐	Kidney Disease ☐	Anemia ☐	Liver Disease ☐
Rheumatoid Arthritis ☐	Shortness of Breathe ☐	Asthma ☐	Visual Impairment ☐
Hearing Impairment ☐	Mobility issues ☐	Chronic Pain ☐	Sleeping problems ☐
Back pain ☐	Osteo Arthritis ☐	Seizures ☐	Other ☐

I declare, the information stated on this form is true and competed to the best of my ability.

Signature of patient/Legal guardian Date

Please bring list of medications to review with the physician