

Patient Information			
Last Name:		Given Names:	
Date of Birth: dd / mm / yyyy	Age:	Health Card:	VC:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	
Street Address:			
City:		Postal Code:	
Home Phone:		Cell Phone:	
Work Information			
Employer:			
Occupation:		Supervisor:	
Employer Address:			
City:		Work Phone:	
Emergency Contact			
Contact Person:		Relationship to Patient:	
Contact Phone #1:		Contact Phone #2:	
Personal Medical History			
Medical History <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Attack / Heart Disease / Heart Failure <input type="checkbox"/> Asthma or Chronic Lung Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis, Gout, or Joint Injuries <input type="checkbox"/> Depression, Anxiety or Mental Health Issues <input type="checkbox"/> Bone Fractures <input type="checkbox"/> Other: _____ Cancer <input type="checkbox"/> Breast <input type="checkbox"/> Colon/Bowel <input type="checkbox"/> Prostate <input type="checkbox"/> Lung <input type="checkbox"/> Other _____		Surgical or Procedure History <input type="checkbox"/> Tonsils/Adenoids When? _____ <input type="checkbox"/> Appendix When? _____ <input type="checkbox"/> Bowel Surgery When? _____ <input type="checkbox"/> Joint Replacement When? _____ Details _____ <input type="checkbox"/> Colonoscopy When? _____ <input type="checkbox"/> Upper Endoscopy When? _____ <input type="checkbox"/> Cosmetic Surgery When? _____ Details _____ <input type="checkbox"/> Wisdom Teeth When? _____ <input type="checkbox"/> Other: _____ When? _____	
For Women Only			
# of pregnancies:		# miscarriages/abortions:	# of children:
Date of Last Pap smear:		Date of Last Mammogram:	

Medications					
<i>Please list all medications, including non-prescription drugs and herbals.</i>					
Medication	Strength/Dose	# Tablets/Dose	How often		
Pharmacy:		Location:			
Allergies					
<i>Please list all drug, food, and environmental allergies.</i>					
Allergy	Type of Reaction (e.g., rash, breathing problems, etc.)				
Habits					
Smoking Status: <input type="checkbox"/> Never Smoked					
<input type="checkbox"/> Currently Smoke: How many packs per day? _____ For how many years? _____					
<input type="checkbox"/> Quit Smoking: When did you quit? _____ For how long did you smoke? _____					
Alcohol Consumption: How many drinks per week? _____					
Recreational drug use:					
Family History					
Medical Condition	Relative(s) with condition	Age when diagnosed	Medical Condition	Relative(s) with condition	Age when diagnosed
High Blood Pressure			Colon/Bowel Cancer		
Heart Disease			Breast Cancer		
Stroke			Arthritis		
Diabetes			Depression		
High Cholesterol			Bipolar Disorder		
Asthma			Schizophrenia		
Other Cancers (provide details):					
Other Conditions (provide details):					