# Big Bay Family Practice

# HEALTH QUESTIONNAIRE

The purpose of this questionnaire is to ensure that your 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. Due to the large number of patients on the waiting list, the response to your request may be delayed some time. Thank you.

## Patient Demographics

Name: ____________________________________________

Date of Birth(yy/mm/dd): ___________________ OHIP # ______________________________

Street Address: ____________________________________________________________________

City: ____________________________________ Postal Code: __________________________

Home Phone: ___________________Cell: ____________________ Work: ___________________

Previous Family Physician ______________________ Last seen: _________________

**Which is your preferred phone number?** **O** Home **O** Cell **O** Work

**May we leave messages on your preferred phone number?**

**O** Yes, any message **O** Only Appointment Information **O** No messages

Email Address:______________________________________________

**HOW DID YOU HEAR ABOUT US?**

Family/friend ◯ Internet/google search ◯ Poster/Flyer ◯

**List Current Medical Conditions:**

| | |
|---|---|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

**List your Current prescription medications:**

| Name | Strength | frequency taken |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

**List your non-prescription drugs (over-the-counter drugs, vitamins, herbs, etc )**

| 1- |
|---|
| 2- |
| 3- |
| 4- |

**List allergies or side effects to medications.**

| Name of medication | Reaction you had |
|---|---|
| 1- | |
| 2- | |
| 3- | |
| 4- | |
| 5- | |

## Past Medical History

### 1- Surgeries:

| Operations/procedures | Reason | Year |
|---|---|---|
| 1- | | |
| 2- | | |
| 3- | | |
| 4- | | |
| 5- | | |

### 2- Hospitalizations.

| Name of hospital | Reason | Year |
|---|---|---|
| 1- | | |
| 2- | | |
| 3- | | |
| 4- | | |
| 5- | | |

### 3- Vaccinations

| Tetanus within past 10 years | Yes | No |
|---|---|---|
| Pneumonia | Yes | No |
| Shingles Vaccine | Yes | No |
| Hepatitis A, B, both | Yes | No |
| Flu vaccine | Yes | No |
| HPV Vaccine | Yes | No |

### 4- OBGYN History – if applicable.

| Total pregnancies: | |
|---|---|
| Miscarriages: | |
| Term deliveries: | |
| Preterm Deliveries: | |
| Obstetrical Complications: | |
| Last PAP test: | |
| Last Mammogram: | |
| Last BMD: | |

**Family Medical History:**

| Disease | Relationship / Approximate Age of Onset |
|---|---|
| Heart Disease | |
| High Cholesterol | |
| Diabetes | |
| Asthma | |
| Stroke | |
| Dementia | |
| Cancer | |
| Psychiatric problem | |
| Other | |

**Social History:**

1- **Marital status**:

Never married ◯ Married ◯ common law ◯ Separated ◯ Divorced ◯ Widowed ◯

2- **Occupation: ________________________________________________________________________**

3- **Tobacco:**

Never smoked ◯ smoker ◯ Ex-smoker ◯ passive smoke contact ◯

Cigarettes per day: _________

4- **Alcohol:**

None ◯ Light ◯ Moderate ◯ Heavy ◯ Ex-Drinker ◯

How many drinks per week on average? _________________________________________________

5- **Street Drug:** Yes ◯ No ◯

What drugs have you used? ______________________________________________________________

6- **Intercourse:**

Have you ever had sex? Yes ◯ No ◯

Are you sexually active now? Yes ◯ No ◯

Any contraceptive method do you use, if any? ______________________________________________

By signing this questionnaire, I acknowledge that all information is correct and complete, and I accept the responsibility of my refusal if I conceal any information regarding my medical history. I am also aware that this application does not mean that my registration has been finalized under the care of Dr.Henry

Signature:_________________________________ Date:_________________________