PERSONAL INFORMATION
(CONFIDENTIAL)

Today's Date: ____________________

CONTACT INFORMATION					
First Name					
Last Name					
HOME					
Address				**Suite**	
City		**Province**		**Postal Code**	
Home Phone			**Cell Phone**		
Home Email					
WORK					
Company Name				**Title**	
Address				**Suite**	
City				**Postal Code**	
Work Phone			**Work Fax**		
Work Email				☐ check, if read by your Exec Asst/other	
CONFIDENTIAL EMAIL					
Preferred Method of Communication	☐ Email	☐ Cell Phone	☐ Office Phone	☐ Home Phone	
Name of Executive Asst (if applicable)					
Executive Asst Work Phone					
Executive Asst Email					
EMERGENCY					
Contact Name				**Relation**	
Contact Phone					

PERSONAL INFORMATION			
Health Card Number		**Version Code**	
Date of Birth	**Month:** **Day:** **Year:**	**Marital Status**	
Family Physician		**Phone**	
Address		**City/Postal Code**	

HEALTH QUESTIONNAIRE

HEALTH CONCERNS AND GOALS THAT YOU WOULD LIKE US TO HELP YOU WITH
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2
3
4
5

MAJOR ILLNESSES / HOSPITAL ADMISSIONS / SURGERIES		
Year	Description	Hospital/M.D.

YOUR FAMILY HEALTH HISTORY

Please indicate all family history issues that you are aware of that would help us in assessing your personal health risk
Indicate the AGE when the health concern developed; CIRCLE THE AGE – if this was the cause of death

	Father	Mother	Siblings	Maternal Grandparents	Paternal Grandparents	Comments
Heart Attack						
Heart Disease						
Stroke						
High Blood Pressure						
Cancer:						
Breast						
Prostate						
Lung						
Other type: ____________________						
Arthritis						
Osteoporosis (bone loss)						
Obesity						
Diabetes						
Mental Health Issues:						
Depression						
Mania						
Other: ____________________						
Alcohol/Drug Abuse						
Thyroid (hypo or hyper)						
Other:						

ALLERGIES			
Drug Allergies		**Environmental Allergies**	
Drug	Reaction	Allergen	Reaction

MEDICATIONS		
List CURRENT prescriptions, over-the-counter drugs, inhalers, topical lotions and creams **YOU ARE PRESENTLY ON**		
Name	Dosage	Frequency Taken
List OCCASIONAL prescriptions, over-the-counter drugs, inhalers, topical lotions and creams that **YOU HAVE OFTEN USED in the PAST YEAR**		
Name	Dosage	Frequency Taken

VITAMINS, SUPPLEMENTS AND HERBAL REMEDIES		
Product	Dosage	Frequency Taken

IMMUNIZATIONS Indicate the last date (year) which you had a vaccine		
☐ Tetanus	☐ Hepatitis A	☐ Hepatitis B
☐ Pneumovax	☐ Polio	☐ BCG
☐ Flushot	☐ MMR *Measles, Mumps, Rubella*	☐ TB Skin (Mantoux) Test

MEDICAL HISTORY – MEN and WOMEN

Check if you have had a recent change (past 6-12 months) in the following

☐ Weight	☐ Decrease ☐ Increase How Much? ______________________________
☐ Appetite	☐ Decrease ☐ Increase
☐ Energy	☐ Decrease ☐ Increase
☐ Sleep	☐ Decrease ☐ Increase
☐ Memory	☐ Decrease ☐ Increase

Indicate if you have, or ever had any of the following symptoms / diseases (go across each row)

☐ Dizziness/Fainting spells	☐ Headaches/Migraines	☐ Tremors/hands shaking
☐ Failing Vision	☐ Failing Hearing	☐ Failing Smell
☐ Indigestion/Gas	☐ Heart burn/ ulcer symptoms	☐ Frequent Diarrhea
☐ Frequent Nausea	☐ Frequent Vomiting	☐ Frequent Constipation
☐ Calf pain, when walking/exercising	☐ High blood pressure	☐ Irregular pulse/palpitations
☐ Heart Murmur	☐ Swollen ankles	☐ Shortness of breath
☐ Depression	☐ Phobias	☐ Panic/Anxiety
☐ Bone loss – Osteoporosis, Osteopenia	☐ Muscle weakness and aches	☐ Back Pain/Joint Pain/Arthritis
☐ Exposure to 2nd hand smoke	☐ Wheezing/Asthma	☐ Chest Pain/tightness
☐ High Cholesterol	☐ High Blood Sugar	☐ Low Iron
☐ Urine, Bladder or Kidney infections	☐ Kidney Stones	☐ Nighttime Urination # of times: ______

Women	Men	None	Mild	Mod.	Severe
Hot flashes/night sweats	Night Sweats				
Depressed mood	Depressed mood				
Anxiety, nervousness, panic	Anxiety, nervousness, panic				
Irritability or Mood Swings	Irritability or Mood Swings				
Insomnia/Poor Sleep	Insomnia/Poor Sleep				
Skin dryness/ itchiness/hair loss	Skin dryness/ itchiness/hair loss				
Decreased Muscle Mass, strength, endurance	Decreased Muscle Mass, strength, endurance				
Vaginal dryness	Difficulty with Erection or Ejaculation				
Decreased/Loss of sex drive	Decreased/Loss of Sex Drive				

MEN ONLY

Have you noticed a slow urinary stream? Or difficulty voiding?	☐ Yes	☐ No
Are you experiencing burning or discharge from penis?	☐ Yes	☐ No
Any testicular pain or swelling?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation	Date of last period	Days of flow ____ days Length of cycle ____ days

Do you experience ☐ Menstrual Irregularity ☐ Irregular Spotting ☐ Heavy Bleeding/Clots ☐ Vaginal Discharge

Birth control method If BC pill, please name

Number of pregnancies _____ Number of live births _____ Number of Abortions/Miscarriages _____

Do you experience bloating or mood swings around your period?	☐ Yes	☐ No
Do you have lumpy breasts? Or experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Any pelvic pain?	☐ Yes	☐ No

LIFESTYLE ISSUES						
Exercise	☐ Sedentary (i.e., no exercise / minimal)					
	☐ Mild exercise (i.e., walk 20min up to 3x / week)					
	☐ Occasional vigorous exercise (i.e., aerobic / strength activity up to 4x / week)					
	☐ Regular vigorous exercise (i.e., aerobic / strength activity 4x or more /week)					
Diet	Are you dieting or on a weight loss program?	☐ Yes	☐ No			
	If yes, please describe:					
	Meals you eat in an average day? ☐ breakfast ☐ lunch ☐ dinner Number of snacks/day: ___________					
	Salt intake level	☐ High	☐ Med	☐ Low		
	Fat intake level	☐ High	☐ Med	☐ Low		
Beverages	☐ Coffee _____ Cups/day	☐ Tea _____ Cups/day	☐ Pop _____ Cups/day	☐ Milk _____ Cups/day	☐ Carbonated Water _____ Cups/day	Other Drinks: _____ Cups/day
Alcohol	☐ None	☐ Wine _____ Glasses/wk	☐ Beer _____ Glasses/wk	☐ Liquor _____ Glasses/wk		
Tobacco	☐ None	Cigarettes _____ /day	Chew _____ /day	Pipe _____ /day	Cigars _____/day	
	_____ # of years	Or year quit :_____________				
Street Drugs	☐ None	☐ Yes	Type:			

TESTS AND EXAMS

Test/Exam	Last completion date	Result
☐ Physical Exam		
☐ Blood work (blood sugar, cholesterol)		
☐ PAP smear		
☐ Rectal Prostate exam		
☐ Mammogram		
☐ Ultrasound Breasts		
☐ Bone Density		
☐ Dental Exam		
☐ Eye Exam		
☐ Hearing test		
☐ Colonoscopy		
☐ Ultrasound Abdomen		
☐ Ultrasound Pelvis/Prostate		
☐ Chest X-ray		
☐ Upper GI / /Barium Enema X-ray		
☐ Stress Test		
☐ Angiogram		
☐ ECG		
☐ Pulmonary Function Test		
☐ CT Scan: Area - _________________		
☐ MRI Scan: Area - _________________		
Other:		