Patient Information Questionnaire

Please fill out and bring with you to your appointment

Name ____ Health Card _____________________________ Version ______ DOB (DD/MM/YYYY) ___________

Address ____ Suite _________ City ___________________ Province ______ Postal Code ________

Home No. __________________________________ Work No. __________________________________ Cell No. __________________________________

Occupation ____ Family Physician ____

Please list all the medications you are currently taking including prescription, inhalers, herbal or non-prescription drugs (include the dose and how often you take the medicine):

____

____

____

Please list any drug allergies:

____

____

____

SURGICAL HISTORY:

Please list below all surgical procedures you have had

Date:	Surgery:	Anesthetic General	Local	Unknown
___________	______________________________________	☐	☐	☐
___________	______________________________________	☐	☐	☐
___________	______________________________________	☐	☐	☐
___________	______________________________________	☐	☐	☐

Have you or anyone in your family ever had problems with anesthetics?

MEDICAL HISTORY:

Please check beside any of the following medical conditions that apply to you:

__asthma
__arthritis
__bleeding problems
__blood clots
__ broken bones
__cancer
__ circulation problems
__diabetes
__drug or alcohol dependency
__ fibromyalgia
__frequent skin infections
__ frequent urinary tract infections

__ gastrointestinal disease
__ heart disease
__hepatitis
__ high blood pressure
__ kidney disease
__liver disease
__lung disease
__neurological problems
__ pneumonia
__ skin problems
__stomach problems
__stroke
__thyroid disease

GENERAL HEALTH:

Please list any other medical conditions not listed above: ____

Last dental appointment: ________________________ Any current issues with your teeth? Yes/No (circle response). If yes, please list______________________

Are you a smoker? ________________ If yes, how many cigarettes a day? __________

Do you drink alcohol?______________ If yes, how many drinks per week? __________

Do you use recreational drugs? _______ If yes, which ones? ______________________

I have answered the questions as accurately and truthfully as possible:

Patient Signature: ____ Date: __________________

FOR WSIB PATIENTS:

Claim Number: _____________________________ Date of Accident: _________________________________