**Queenan Family Medicine and Maternity Care**

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"Mindful Medicine for whole body, mind, and spirit"

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 **Patient History for Person Referred for Palliative Care**

**Queenan Family Medicine and Maternity Care**

Please complete this questionnaire in its entirety in order to optimize our time together in your new patient visit. Please bring your OHIP card to the visit for verification. Your answers to this questionnaire are confidential and will not be shared. Please try to provide as much detail as possible. Thank you for your time.

1. Full name as it appears on your OHIP card.
2. Preferred name if different from above
3. Preferred pronouns + gender identity; please note if these differ from your birth gender
4. Date of birth
5. Address Please include town and postal code
6. Primary telephone number with area code (please note home, mobile, or work phone)
7. Alternate telephone if applicable  (please note home, mobile, or work phone)
8. E-mail address, if applicable Please see e-mail policy for appropriate use of e-mail in your medical care. If, after reading the policy, you would not like to communicate with your doctor via e-mail, please note this below.
9. Emergency contact Please include name, relationship, and phone number
10. OHIP number with version code and expiration date
11. Preferred pharmacy
12. How did you hear about Queenan Family Medicine and Maternity Care?
13. Please list your current medical problems, and any medical problems that you have had in the past (excluding surgeries).
14. Please list any surgeries you have had, your surgeon and/or hospital (if you know), and the year when you had the surgery (your best estimate is fine).  If none, please indicate "none"
15. Please list any allergies to medications, foods, or other substances (such as latex). If none, please indicate "none"
16. Please list all the medications you currently take, the dosage, and how often you take them.  Please feel free to attach list from your pharmacy. Please include any vitamins, over-the-counter (OTC) medications, and herbal/nutritional supplements you regularly use as well.
17. Do you have any other healthcare providers currently involved in your care? If so, please list their name and for what condition you see them. If none, please indicate "none"
18. Please describe any alternative, integrative or complementary modalities of health care you are currently using or have used in the past. If any were used for a specific problem or diagnosis, please indicate the reason as well.  If none, please indicate "none"
19. Please describe who is in your household (with whom do you live?). Do you have any concerns with the safety of your living situation?
20. Please list the highest level of education you have completed. How do you prefer to take in information: spoken, written, diagrams/pictures, others?
21. Please describe your occupation and approximately how many hours a week you work.  If you are retired, please describe your former occupation.
22. Please describe the hobbies or activities you most enjoy. What brings you joy in your life?
23. Are you a part of a faith community, religion, and/or do you hold spiritual beliefs?
24. If you currently smoke cigarettes, cigars, or use chewing tobacco, or have done so in the past, please list when you started smoking, how many cigarettes/cigars you smoke(d) a day, and how many years you have smoked. If you use e-cigarettes, please state so. If you are a former smoker, please indicate when you quit.  If you have never smoked, please indicate "never"
25. On average, how many servings of alcohol do you drink per week (serving = 12oz 5% beer/cider/cooler, 1.5 ox shot hard liqour, 5 oz glass wine) ?  Have you ever drunk more heavily than this? If so, how much, and when did you cut down/quit? When was the last time you had more than 4 drinks in a session? If none, please indicate "none"
26. Please indicate if you use or have used in the past any street drugs, including marijuana, non-prescribed prescription pills, crack/cocaine, heroin, methamphetamine, etc.?  If none, please indicate "none"
27. Any concerns with weight loss, fevers, chills, excessive fatigue or low energy?  If none, please indicate "none"
28. Any difficulties with speaking or communicating. If none, please indicate "none"
29. Any trouble with persistent pain? Is treatment prescribed for it? Is this helping? If none, please indicate "none"
30. Any trouble with persistent shortness of breath?  If none, please indicate "none"
31. Any trouble with persistent nausea or vomiting?  Any difficulties with swallowing? Changes in appetite? If none, please indicate "none"
32. Any problems with persistent or abnormal bleeding? If none, please indicate "none"
33. Any problems with loss of bowel/bladder control? If none, please indicate "none"
34. During the past month, have you been bothered often by feeling down, depressed, or hopeless? During the past month, have you been bothered often by little interest or pleasure in doing things? If none, please indicate "none"
35. Please use this space to express any other thoughts or concerns you may have that were not addressed in the previous questions. Thank you for taking the time to complete this important questionnaire that will help us maximize our time together.