Queenan Family Medicine and Maternity Care
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New Adult Patient Medical History
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. Date of birth

4. Address *Please include town and postal code*

5. Primary telephone number with area code

6. Alternate telephone *if applicable*

7. 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.*

8. Emergency contact *Please include name, relationship, and phone number*

9. OHIP number

10. How did you hear about Queenan Family Medicine and Maternity Care?

11. Please list any current medical problems that you have. *If none, please indicate "none"*

12. Please list any medical problems that you have had in the past (excluding surgeries). *If none, please indicate "none"*

13. 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"*

14. Please list any allergies to medications, foods, or other substances (such as latex). *If none, please indicate "none"*

15. Please list all of the medications you currently take, the dosage, and how often you take them. *Please include any vitamins, over-the-counter (OTC) medications, and herbal/nutritional supplements you regularly use as well.*

16. 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"*

17. Please describe any alternative, integrative or complementary modalities of health care you are utilizing currently, or have utilized in the past. If any were used for a specific problem or diagnosis, please indicate the reason as well. *If none, please indicate "none"*

18. Please describe any medical problems that members of your family have. *Include such problems as diabetes, heart disease, breast/ovarian/prostate/colon cancer, stroke, etc. Please list who in your family has the medical problem, along with if they are currently living or not.*

19. **Vaccinations:** Please state the date of your last Tetanus, Pneuomoccocal, Flu, and Shingles vaccination, if received. *If not certain, approximate dates are fine.*

20. **Adult health preventive screening**:

- Has your cholesterol been checked? If so, when and what were the results?

- If you are over age 50, have you had colon cancer screening (e.g. a colonoscopy or stool cards)?

21. **Women's health questions**:

- Have you been pregnant? If so, How many pregnancies have you had, and how many children have you given birth to?

- Have you had a pap smear? If so, date of your last Pap Smear and any history of abnormals.

- Have you had a mammogram? If so, date of your last mammogram and any history of abnormals.

- When was the date of your last menstrual period? Have you reached menopause?

- Have you had bone density screening (DEXA scan)? If so, date of your last DEXA and results.

22. Please describe who is in your household (with whom do you live?). Do you have any concerns with the safety of your living situation?

23. Please list the highest level of education you have completed. How do you prefer to take in information: spoken, written, diagrams/pictures, others?

24. Please describe your occupation and approximately how many hours a week you work.

25. Please describe the recreational activities you most enjoy.

26. 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"*

27. On average, how many alcoholic drinks do you drink per week? 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"*

28. Please indicate if you use or have used in the past any street drugs, including marijuana, non-prescribed prescription pills, crack/cocaine, heroine, methamphetamine, etc.? *If none, please indicate "none"*

29. Please describe any recent changes in your weight and any concerns you have about your weight. Please describe any recent fevers, chills, excessive fatigue or low energy. *If none, please indicate "none"*

30. Please describe any recent changes you have had in your vision, hearing, ability to smell, chew, speak, or swallow? *If none, please indicate "none"*

31. Please describe any recent episodes of chest pain, shortness of breath, wheezing, heart racing or skipping beats, difficulty breathing while sleeping, or leg swelling. *If none, please indicate "none"*

32. Please describe any problems you have had recently in your digestion, including any nausea, vomiting, abdominal pain, diarrhea, constipation, blood in stool, change in stool frequency, size, color, or consistency. *If none, please indicate "none"*

33. Please describe any recent problems with back pain, joint pain, or injuries. *If none, please indicate "none"*

34. Please describe any recent problems with headaches, dizziness, or unusual numbness or tingling sensations. *If none, please indicate "none"*

35. During the <u>past month</u>, 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"*

36. Do you have any questions or concerns about sexual function? *If none, please indicate "none"*

37. Please describe any recent changes in your urinary function including any pain with urination, frequent urination, blood in the urine, unusual discharge, any difficulty stopping or starting a stream of urine, or any episodes of incontinence or leakage of urine. *If none, please indicate "none"*

38. 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.*