**HEALTH QUESTIONNAIRE**

The purpose of this questionnaire is to ensure that your electronic medical record contains complete and up to date information so we can provide you with optimal comprehensive care. Please print this form, complete it to the best of your ability, and **fax it (705) 792-4009 or email to: doctorkwright@gmail.com**. Strict confidentiality is ensured. Completion of this form does not necessarily constitute enrolment into Dr. Wright’s practice. If for some reason, you are not enrolled, this information will be destroyed

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| **Name** (Last, First, M.I): | | | | | | | | | **DOB:** |
| **Previous Family Physician: City: Last Seen:** | | | | | | | | | |
| **CURRENT MEDICAL HISTORY** | | | | | | | | | |
| **List Current Conditions** | | | | | | | | | |
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| **Measurements** | | | | | | **Height: Weight**  **Blood Pressure** (if known): | | | |
| **List the details of your prescription medication below** (if unable to list, bring them with you to the clinic) | | | | | | | | | |
| **PRESCRIPTION MEDICATIONS Name** | | | | | | | **Strength** | **Frequency Taken** | |
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| **MEDICATION ALLERGIES**  **List the details of allergies or side effects to any medications** | | | | | | | | | |
| **Name of Medication** | | | | | | **Reaction you had** | | | |
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| **PAST MEDICAL HISTORY** | | | | | | | | | |
| **Immunizations (Please Include Dates):** | | | | | | | | | |
| Shingrix(shingles)  Yes No | | | | | | | | | |
| Tetanus within past 10 years  Yes No | | | | | Pneumonia Shot Yes No | | | | |
| Chicken Pox Vaccine Yes No | | | | Hepatitis (Select type: A B Unsure) | | | | | |
| **Type or Surgery or Procedure** | | **Date** | **Reason or Outcome** | | | | | | |
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| **Other Hospitalizations Name of Hospital** | | **Date** | **Reason or Outcome** | | | | | | |
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| **Other Past Problems/Injuries** | | **Year** | **Outcome** | | | | | | |
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| **Obstetrical History (indicate number if any)** | | | | | | | | | |
| Total Pregnancies: Term Deliveries: Preterm Deliveries: | | | | | | | | | |
| Miscarriages: Pregnancy terminations: Living: | | | | | | | | | |
| **FAMILY MEDICAL HISTORY** | | | | | | | | | |
| **Please indicate relationship and approximate age of onset for blood relatives with any of the following conditions** | | | | | | | | | |
| **Disease** | | | | **Relationship/Approximate Age of Onset** | | | | | |
| Heart Disease | | | |  | | | | | |
| Diabetes | | | |  | | | | | |
| Colon cancer | | | |  | | | | | |
| Breast cancer | | | |  | | | | | |
| Dementia/Alzheimer’s | | | |  | | | | | |
| Psychiatric Illness | | | |  | | | | | |
| Other | | | |  | | | | | |
| **SOCIAL HISTORY** | | | | | | | | | |
| **Marital Status:**  Never MarriedMarried Common Law Separated Divorced Widowed | | | | | | | | | |
| **Occupation:**  Student  Retired  Disability Social Assistance | | | | | | | | | |
| **Recreation/Hobbies:** | | | | | | | | | |
| **Medical Considerations with respect to Religion:** | | | | | | | | | |
| **Lifestyle** | What best describes your diet: very poor poor fair good excellent  What best describes your activity level: minimal fair good excellent | | | | | | | | |
| **Tobacco** | What is your smoking status: never smoked ex-smoker year quit:  current smoker #cigarettes/day: vape | | | | | | | | |
| **Alcohol** | What best describes your drinking habits:  none 0-3/week 4-7/weeks 8-12/week more than 12/week  Ex-drinker year stopped: | | | | | | | | |
| Are you concerned about the amount you drink? Yes No | | | | | | | | |
| Have you considered cutting down? Yes No | | | | | | | | |
| Have you ever had a problem with Alcohol? Yes No | | | | | | | | |
| Are you prone to “binge” drinking? Yes No | | | | | | | | |
| **Street Drugs** | What best describes your recreational drug use:  Never 0-3/week daily Heavy  ex-user year quit: | | | | | | | | |
| Have you ever given yourself street drugs with a needle? Yes No | | | | | | | | |
| What street drugs have or are you using? Last used: | | | | | | | | |
| **PREVENTION AND WELLNESS** | | | | | | | | | |
| **Preventive Screening Tests (please give approximate dates for the following)** | | | | | | | | | |
| **Women less than 70 years old**    **Over 40 years old** | | | | Date of last Pap (recommended every 3 years):  Result: | | | | | |
| Date of last Mammogram (recommended every 2 years):  Result: | | | | | |
| **Men and Women**  **Over 50 years old** | | | | Date of Last Stool Test for Colon Cancer:  Result: | | | | | |
| Date of last Colonoscopy:  Result and when repeat recommended: | | | | | |
| Date of last Cholesterol Test: | | | | | |
| **Men over 50 years old** | | | | Date of last PSA test (recommended every 2 years): | | | | | |
| **PERSONAL HEALTH GOALS** | | | | | | | | | |
| In what areas of your life would you like to make changes? | | | | | | | | | |
| In what areas would you like assistance? | | | | | | | | | |
| Is there any additional information that may be helpful for us to know? | | | | | | | | | |