Patient Medical History Form

Demographic Information

First Name	Middle Name	Last Name

Maiden Name (if applicable)	Preferred Name	Gender ☐ Male ☐ Female ☐ Other

Date of Birth (dd-Mon-yyyy)	Marital Status ☐ Single ☐ Common-Law ☐ Married ☐ Widowed ☐ Divorced ☐ Other_____

Address	City/Town	Province	Postal Code

Preferred Contact: ☐ Home ☐ Cell ☐ Work

Home Phone	Cell Phone	Work Phone

Email Address:

Emergency Contact

Name	Relationship to You	Contact Number

Allergies

☐ **No known Allergies**

Allergen	**Reaction** (anaphylaxis, swelling, rash, nausea, vomiting, fever, etc)	**Allergen**	**Reaction** (anaphylaxis, swelling, rash, nausea, vomiting, fever, etc)

Medications (Please list all medications that you are currently taking

☐ **No Medications**

Which Pharmacy do you primarily use? _____

Supplements ☐ None

Please circle any supplements that you are taking:
Calcium / Vitamin D / Vitamin C / Multivitamin / Iron / Fish Oil / Potassium / Fiber / Selenium / Melatonin / Probiotic
Other: _____

Hospital Admissions/Surgical & Broken Bone History (please use provided spaces below)

☐ **No Previous Surgical History**

Year	Illness or Operation	Year	Illness or Operation

FLIP OVER

Have you ever broken any bones or experienced a fracture? ☐ YES ☐ NO
If yes, where? _____ Do you have any metal screws? ☐ YES ☐ NO

Medical History

Have you ever been treated for any of the following medical conditions? Please indicate year diagnosed.

- ☐ Crohn's Disease
- ☐ Irritable Bowel
- ☐ Acid Reflux / Heartburn
- ☐ Respiratory Problems
- ☐ Cancer
  Type: _____
- ☐ Arthritis / OA / RA
- ☐ Heart Disease
- ☐ Fibromyalgia
- ☐ Thyroid Problems
- ☐ Diabetes
  Type: _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Depression / Anxiety
- ☐ Migraine Headaches
- ☐ ADHD
- ☐ Additional medical conditions:
  _____
- ☐ Anemia
- ☐ Epilepsy / Seizures
- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Asthma

☐ **No Medical History to Report**

Family History

Please check off any known medical problems for any relatives and assign accordingly

Medical Problem/Issue	Family Member	Medical Problem/Issue	Family Member
☐ Diabetes	_____	☐ Breast Cancer	_____
☐ Heart Disease	_____	☐ Colon Cancer	_____
☐ High Blood Pressure	_____	☐ Ovarian Cancer	_____
☐ High Cholesterol	_____	☐ Prostate Cancer	_____
☐ Alcohol Abuse	_____	☐ Skin Cancer	_____
☐ Depression	_____	☐ Other _____	_____

☐ **No Known Family History to Report** ☐ **Unknown-Adopted**

Social History

Occupation:
- ☐ _____
- ☐ Homemaker
- ☐ Unemployed
- ☐ Retired

Education Level
- ☐ High School
- ☐ College
- ☐ University
- ☐ Technical School
- ☐ Other _____

Residence
- ☐ Apartment
- ☐ Condo
- ☐ House
- ☐ Farm / Acreage
- ☐ Manor
- ☐ Points West Living
- ☐ Other_____

Alcohol
- ☐ None

Beer / Wine / Liquor / Other
(Circle Applicable)
Number of Drinks: _____/
day /week / month / year

Tobacco/Smoking
- ☐ Non-Smoker
- ☐ Ex-Smoker
  Quit Date: _____
- ☐ Smoker
  Cigarettes _____/ day
  Years Smoked _____
- ☐ Chew _____/ day
- ☐ Vape
- ☐ Cannabis/Marijuana /CBD Oil

Drug Use Status
☐ Never ☐ Past ☐ Current

If current, how often (circle):
Rarely, Occasionally Regularly

Caffeine
- ☐ None
- ☐ Coffee _____/ day
- ☐ Tea _____/ day
- ☐ Soda _____/ day

Sleeping Habits
Average hours of sleep per night: _____

Would you consider your sleep:
- ☐ satisfactory
- ☐ occasionally disturbed
- ☐ mostly disturbed

Type (circle applicable):
Marijuana/cocaine/heroin/
Ecstasy/Mushrooms/Fentanyl
Meth/Opioids/PCP
Other:

Eating Habits
(Check all that apply)
- ☐ Poor
- ☐ Could be better
- ☐ Well-balanced
- ☐ Vegetarian
- ☐ Vegan
- ☐ Gluten-free
- ☐ Carb-free
- ☐ Dairy-free
- ☐ Other_____

How often do you exercise?
- ☐ Never
- ☐ once or twice a year
- ☐ a few times a month
- ☐ 3 -5 times a week
- ☐ Every Day

Routine Questions Asked for Investigations [CHECK ALLTHAT APPLY]

	Y		Y		Y
Liver Disease	☐	Metal Pin, Plate, Screw Type: _____	☐	War injury, gunshot, metal fragments	☐
Renal Disease	☐				
Renal Failure	☐	Aneurysm surgery or clip	☐	Welder, machinist, sheet metal worker	☐
Renal Dialysis	☐	Coronary Artery Stent. Material _____	☐		
Diabetic	☐			Eye / head metal foreign body	☐
Hearing Aid	☐	Coronary artery, heart valve surgery	☐	Deep Brain Stimulator	☐
Inner ear implant	☐			Central Venous Catheter	☐
Claustrophobic	☐	Cardiac Pacemaker or defibrillator	☐	NONE APPLY	☐

Please Sign and Date

Signature	Date Completed