Health Quest
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HEALTH HISTORY QUESTIONNAIRE – Date: _____

(All information is held absolutely CONFIDENTIAL)

Name: _____ P.H.N: _____
(Care Card Number)

Birth Date: _____ Age: _____ M or F (Circle Please)

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Email address:_____ Occupation: _____

Email Consent: New legislation requires that we obtain consent prior to sending emails to our patients
I consent to receiving emails from Health Quest and/or its staff. Yes ☐ No ☐

Emergency Contact Information:

Name: _____ Relationship to you: _____

Contact Numbers: _____

Names of other Healthcare Providers: _____

Are you currently under the care of another Physician? _____

Are you currently taking any medications? Please list: _____

_____

Are you currently on any supplements or remedies? Please list: _____

_____

How did you hear about our clinic? _____

What are your main concerns today and when did they begin?

_____

_____

Have they been diagnosed? _____

Have there been any improvements made? _____

Past/Recent Surgeries? _____

Past/Recent Trauma (Physical and emotional)?

_____

Do you have any allergies? _____

_____

Please indicate any other problems you would like to discuss: _____

_____

Past Medical History

If you have had any of the following conditions below, please check the appropriate box – **P**ast or **C**urrent.

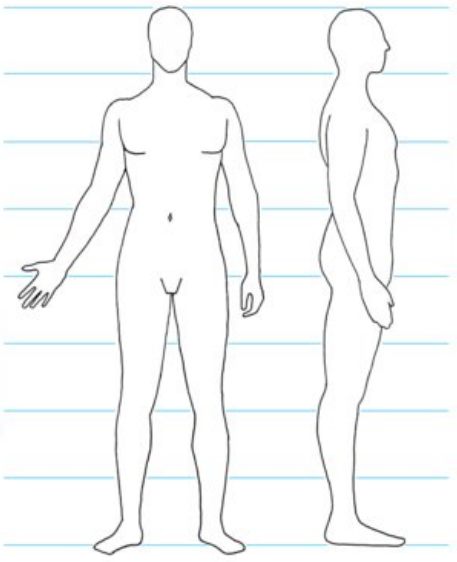
Condition	P	C	Condition	P	C	Condition	P	C	Condition	P	C
Abscess			Frequent Colds			Malaria			Seizures		
Abortion			Gallstones			Miscarriage			Skin Disease		
Alcoholism			Gonorrhoea			Mononucleosis			Sinusitis		
Anaemia			Gout			Multiple Sclerosis			Stroke		
Arthritis			Hay Fever			Mumps			Strep. Throat		
Asthma			Heart Disease			Parasites			Syphilis		
BPH			Hepatitis			Pelvic Inflam. Disease			Thyroid Disease		
Cancer			Herpes			PMS			Tuberculosis		
Chicken Pox			HIV / AIDS			Pneumonia			Typhoid Fever		
Cold Sores			Influenza			Prostatitis			Venereal Warts		
Depression			Kidney Disease			Rheumatic Fever			Warts		
Diabetes			Kidney Stones			Rubella			Whooping Cough		
Emphysema			Leukemia			Scarlet Fever			Worms		
Epilepsy			Low/High BP			Sexual Abuse					

Exam and Imaging History

Indicate date, doctor's name, or place of most recent tests

Physical Exam		**HIV test**	
Pap Smear		**Chest X-ray**	
Prostate Exam		**EKG**	
Mammogram		**STD Screen**	
Colonoscopy		**Cholesterol test**	
TB test		**Blood glucose**	
Bone density test		**Urinalysis**	
Other physical exam		**Fecal Occult Blood**	
Other imaging test		**Other test**	

INDICATE ANY PAINFUL OR DISTRESSED AREAS:



Lifestyle and Social History

Habits	Yes	No	Details	Doctor's Notes
Current Tobacco Use			Packs per day:	
Past Tobacco Use			Packs per day:	
Quit Smoking			When?	
Alcohol consumption			Types: Drinks per week:	
Recreational Drug Use			Type:	
Treated for drug/alcohol abuse?			When?	
Seat Belt Use				
Caffeine Use (coffee, tea, cola)			Type: Cups per day:	
Regular Exercise			Types: How long and how frequent?	

Social	Yes	No	Details	Doctor's Notes
Happy with relationship status?				
Do you have a good support network of family and friends?			Who?	
What is your predominant emotion?				

Lifestyle
Do you enjoy your work? Yes No
Stress Level (please circle): Low Medium High
Stress Source (please circle): Money Job Family/Relationship Other (please describe)
What do you do to relieve stress?
Please rate your energy level on a scale from 1-10 (10 = highest energy)

Sleep	Yes	No	Details	Doctor's Notes
Problems falling asleep				
Problems staying asleep				
Regular bedtime?			Typical bedtime?	
Regular wake up time?			Typical wake up time?	
Wake rested in the morning?			Average hours of sleep per night?	
Dreams?				

Diet	Doctor's Notes
Do you follow a particular diet?	
Known food allergies/intolerances?	
What is your typical breakfast?	
What is your typical lunch?	
What is your typical dinner?	
Snacks? Desserts/Treats?	
How much water do you drink per day?	
What other fluids do you drink and how much per day?	
What is your current weight?	
What was your weight one year ago?	