Patient Questionnaire

Name ________________________________ DoB _____________________

Have you ever had problems/concerns with any of the following conditions?

Allergies	Cancer
High Blood Pressure	Stroke
Lung Problems	Diabetes or Prediabetes
Heart Problems	High Cholesterol
Epilepsy or Seizures	Kidney Problems
Mental Health	Thyroid Problems
Addiction	Recurrent Infections
Liver Problems	Rheumatic Fever
Prostate Concerns	Bone or Joint Problems
Blood Disorder	Problems with Pain
Stomach/Digestion Problems	Incontinence
Erectile Dysfunction	Hernia/Prolapse
Women's Problems	Family Violence
Other	

Please list any medications or natural treatments you are currently taking -

Do you have allergies to any medications? No Yes

Name of Medication	Problem with Medication

Patient Questionnaire

Have any of your Family members had problems with any of the following:

Illness	Relation to you	Age of Diagnosis
Heart Attack/Heart Disease		
Stroke		
Cancer		
Diabetes		
Autoimmune Disease		
Other		

Smoking negatively impacts the health and wellbeing of you and your family:

Are you a smoker? No Yes Would you like to stop smoking? No Yes

Have you ever smoked? No Yes When did you stop smoking? ________________

Do you drink alcohol? No Yes

If yes, how much do you drink? ____________ drinks per day/week/month/year

Is there anything else you would like to tell us? ____

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