

# PERIMETER NORTH FAMILY MEDICINE

Patient Questionnaire

Date:

Name:	Date of Birth:
<b>Past History</b>	
Please list any chronic medical conditions you have.	
1.	4.
2.	5.
3.	6.
Please list any surgical procedures you have ever had, including year of procedure.	
1.	4.
2.	5.
3.	6.
<b>Family History</b>	
Living	Deceased
List any chronic illnesses or cause of death.	
Mother	
Father	
Brothers #	
Sisters #	
<b>Medications</b>	
List medications you currently take on a daily basis including name , dosage and frequency.	
1.	4.
2.	5.
3.	6.
<b>ALLERGIES:</b>	
<b>Social History</b>	
Occupation:	
How much alcohol do you consume in the average week?	
How much tobacco product do you consume on the average day?	
How many children do you have.	
Living ?	Ages & gender?
Deceased?	Age at death & gender?
Women only. Reproductive history.	
Please indicate the number of pregnancies you have had and the outcomes.	
Do you exercise on a regular basis and if so which activities?	
List common leisure time activities.	
Date of last Pap smear:	Date of last Flexible sigmoidoscopy:

