Vcarepoint
MEDICAL
CARE YOU CAN COUNT ON

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

This information helps your healthcare provider understand your health and provide the best possible care.
All information is confidential.

1 PATIENT INFORMATION

Full Name (Please Print): _____ Date of Birth (DD/MM/YYYY): _____

Health Card Number: _____ Phone Number: _____

2 MEDICAL HISTORY

Do you have any of the following medical conditions? (Please check all that apply)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Asthma / COPD
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Arthritis
- ☐ Depression / Anxiety
- ☐ Stroke / TIA
- ☐ Blood Clots
- ☐ Gastrointestinal Disorder
- ☐ Other: _____
- ☐ Migraine / Headaches
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Skin Condition
- ☐ None of the above

Please list any other medical conditions not listed above:

_____

Have you been hospitalized in the past 5 years? ☐ Yes ☐ No If yes, please explain: _____

Have you had any surgeries? ☐ Yes ☐ No If yes, please list and include the year: _____

3 MEDICATIONS

Please list all prescription medications, over-the-counter medications, vitamins and supplements you are currently taking.

Medication / Supplement Name	Dosage	How Often	Prescribed By

Do you need any prescription refills today? ☐ Yes ☐ No If yes, which ones? _____

4 ALLERGIES

Do you have any allergies? ☐ Yes ☐ No

If yes, please list your allergies and the type of reaction:

Allergy (Medication, Food, Other)	Reaction

Common Allergies (Examples)

- Penicillin
- Sulfa (Sulfonamide)
- Latex
- Iodine / Shellfish
- Peanuts / Nuts
- Other Foods
- Other Medications

3 FAMILY HISTORY

Do any of your close family members (parent, sibling, child) have any of the following?

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer: _____
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Thyroid Disorder
- ☐ Mental Health Condition
- ☐ Other: _____
- ☐ None of the above

6 SOCIAL HISTORY

Do you currently:

Smoke or use tobacco? ☐ Yes ☐ No

Drink alcohol? ☐ Yes ☐ No

Use recreational drugs? ☐ Yes ☐ No

If yes:

How often? _____

How much? _____

Diet: ☐ Balanced ☐ Needs Improvement ☐ Special Diet: _____

Physical Activity:

- ☐ Regular (3+ times per week)
- ☐ Occasional (1–2 times per week)
- ☐ Rarely
- ☐ None

Diet:

- ☐ Needs Improvement

7 WOMEN'S HEALTH (IF APPLICABLE)

Are you currently pregnant? ☐ Yes ☐ No If yes, how many weeks? _____ Date of last menstrual period (DD/MM/YYYY): _____

Are you breastfeeding? ☐ Yes ☐ No

8 ADDITIONAL INFORMATION

Is there anything else about your health that you would like your provider to know? _____

_____

9 PATIENT ACKNOWLEDGEMENT

I confirm that the information provided above is accurate to the best of my knowledge.

Patient Signature: _____ Date (DD/MM/YYYY): _____

51 McMurchy Avenue South, Unit 3
Brampton, Ontario L6Y 1Y5
Primary: 905-454-2001
Rollover: 905-454-2056
Fax: 905-454-2069
info@vcarepointmedical.ca
www.vcarepointmedical.com