ANCRON MEDICAL CENTRE

Patient Questionnaire - Please complete at home and bring to your Meet and Greet Appointment or come in 10 to 15 minutes early for your appointment and you can complete it in the office.

Patients Full Name:	
Date of Birth:	
Email Address:	
Mailing Address:	
City:	Postal Code:

Emergency Contact:	Name:	Relationship:
	Phone Number:	

Preferred Pharmacy:

Allergies:

Please list Current Regular Medication (Medication you take regularly including Vitamins)

	Name of medication:	Strength:	How often:
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Please list any previous major surgeries (ex. abdominal/thoracic/joint surgery, tumour removal)

Year:	Type:	Hospital:	Comment:

Do you have any medical conditions that you need to have treatment for regularly?

Year Diagnosed	Diagnosis

Have you had a previous cancer diagnosis?

Year(s)	Diagnosis

When were you last screened for the following:

Screening Test	Date Last Tested	Results
Pap (Cervical Cancer)		
Mammogram (Breast Cancer)		
FIT Test (Colorectal Cancer)		
PSA Blood Test (Prostate Cancer)		

For Female Patients (where applicable): How many pregnancies have you had? _____

Immunization – Have you been immunized for any of the following?

		Date/Year:		
Pneumovax (pneumonia vaccine)	Yes		No	Not sure
Tetanus	Yes		No	Not sure
Measles	Yes		No	Not sure
Hep B (All 3 injections)	Yes		No	Not sure
Herpes Zoster (Shingles)	Yes		No	Not sure
HPV (human Papilloma Virus)	Yes		No	Not sure
Do you usually have the influenza vaccine	Yes		No	Not sure

Lifestyle Questions:

Do you smoke? **Yes** or **No** If yes how many a day? _____ For how many years? _____

Do you drink alcoholic beverages? **Yes** or **No**

If yes, how many a day?_____ or how many a week? For how many years?_____

Have you ever had a history of alcohol or substance abuse/addiction? **Yes** or **No**

Do you or have you recently experienced any of the following:

Weight Loss	Yes	No
Loss of appetite	Yes	No
Change of bowel habits	Yes	No
Wounds that take a long time to heal	Yes	No

Family History:

Tick if anyone in the family has any of the following? Please write how they are related to you?

Thyroid Disease		Endometriosis		Asthma		Breast Cancer	
Cancer		Bleeding problems		Chronic Bronchitis		Colorectal Cancer	
Kidney Disease		DVTs (Clots)		IBS		Prostate Cancer	
Diabetes		High Blood Pressure		Strokes		Ovarian Cancer	
Epilepsy		Heart Attacks		Liver Disease		High Cholesterol	
Heart Disease							