Limeridge Health Centre
310 Limeridge Rd. W.
Hamilton, ON. L9C 2V2
P(289)755 9000   F(289)755 8000

PATIENTS HEALTH PROFILE

All questions in this questionnaire are strictly confidential and will become part of your medical record

NAME		☐ M ☐ F	DOB:	
MARITAL STATUS:	☐ Single ☐ Partnered ☐ Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Widowed Occupation ______			
CHILDHOOD ILLNESS:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken pox ☐ Rheumatic Fever ☐ Polio			
IMMUNIZATIONS :	Child :	All recommended childhood immunizations (including high school)	☐ Yes ☐ NO	
IMMUNIZATIONS :	Adult	☐ Tetanus ☐TdPolio ☐ Influenza ☐ Chicken pox ☐ TB ☐ MMR measles mumps rubella		
Males PSA ☐ Yes ☐ No Date ______	☐ Pneumococcus pneumonia ☐Hepatitis B ☐ Hepatitis A ☐ Step Test ☐ HPV cervical cancer ☐ Shingles Herpes zoster ☐TB			
OTHER PREVENTATIVE HEALTH MEASURES :	Last complete physical exam :	Female: Date of last Pap :	Female : Date of last mammogram	

MAJOR MEDICAL PROBLEMS DIAGNOSED IN THE PAST (e.g. diabetes, heart attack, stroke, arthritis, asthma)		
(1)	(4)	(7)
(2)	(5)	(8)
(3)	(6)	(9)

SURGERIES

YEAR	REASON	HOSPITAL

OTHER HOSPITALIZATIONS

YEAR	REASON	HOSPITAL

HAVE YOU EVER HAD A BLOOD TRANSFUSION?	☐ YES ☐ NO

DRUGS (PRESCRIPTION AND NON PRESCRIPTION)	
List prescribed drugs you take regularly	List over the counter drugs, e.g. vitamins, etc...

WHAT PHARMACY / PHARMACIES DO YOU USE TO GET YOUR PRESCRIPTION DRUGS?
→

ALLERGIES AND OTHER SERIOUS SIDE EFFECTS TO MEDICATIONS	
NAME OF DRUG	REACTION YOU HAD

EXERCISE	Regular exerciser	☐ YES	☐ NO
ALCOHOL	Do you drink alcohol?	☐ YES	☐ NO
TOBACCO	Do you use tobacco?	☐ YES	☐ NO
DRUG	Do you currently use recreational or street drugs	☐ YES	☐ NO
	Have you ever given yourself street drugs with a needle	☐ YES	☐ NO

	AGE	SIGNIFICANT HEALTH PROBLEMS
MOTHER		
FATHER		
SIBLINGS	GENDER, AGE	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
CHILDREN	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
GRANDMOTHER MATERNAL		
GRANDFATHER MATERNAL		
GRANDMOTHER PATERNAL		
GRANDFATHER PATERNAL		

I HAVE A LIVING WILL	☐ YES	☐ NO

PRINT NAME: ______________________________

SIGNATURE: ______________________________ DATE: ______________

☐ Book Physical Exam ☐ Consent for Release of Medical Information

☐ Chart Transfer ☐ Health Care Connect ☐ Continue Care with Previous FP