Northern Shores Medical Clinic

Please fill out the form honestly and with as much detail as possible. All information will remain confidential. All applicants will be considered; we do not discriminate based on age, sex, race, medical condition(s), sexual orientation, or substances of use/abuse.

Please return completed paper copies in the mail to Northern Shore Medical Clinic, 10 Maplewood Ave. North Bay, ON, P1B 5H2.

History Questionnaire

Date:
Full Name:
Date of Birth:
Health Card Number & version code: Expiry Date dd/mm/yyyy:
Contact Number(s): Can messages be left at this number?
Gender:
Pharmacy:
Occupation/Company:
Are you single ❑, married ❑, common-law ❑, widowed ❑, separated ❑, divorced, other ❑,? Put a ✓ in the box that relates to you.
If yes to married or common-law please answer the following: Spouse/Partner's Name: Is your Spouse/Partner looking for a family doctor as well? If so, please have them fill out a questionnaire.
Dependent(s) & Age(s): If yes, answer below Vaginal/c-section/or adoption? How many pregnancies? How many deliveries? How many abortions/miscarriages?
What immunizations have you had? If available, please attach a copy of your immunization.

Have you had any surgeries? ○ If yes, what were they and what year did surgery happen?
Do you currently have a family doctor? If yes, why are you seeking to change family doctor? Why are you no longer with him/her? Who was your previous family doctor?
Do you smoke? ○ If yes, how many per day and for how many years?
Do you drink alcohol? ○ If yes, how many per week and for how many years?
Do you use any recreational street drugs? ○ If yes, what kind and how often?
Does anyone in your immediate family (parents, grandparents, siblings or children) have any major medical conditions? (ex: heart attack under the age of 50, cancer, diabetes, depression, blood clots) ○ If yes, please list the condition, their relation to you, and the age the condition was diagnosed.

Check any medical conditions you may have & elaborate in the same box:

❑ Diabetes (specify type):	❑ High blood pressure	❑ Thyroid condition
❑ Blot clots (legs/lungs)	❑ Stroke	❑ High cholesterol
❑ Heartburn/Reflux	❑ Arthritis	❑ Seizure
❑ Mental health condition(s):	❑ Breathing condition(s):	❑ Heart condition(s):
❑ Bowel condition(s):	❑ Kidney condition(s):	❑ Skin condition(s):
❑ Reproductive condition(s):	❑ Urinary condition(s):	❑ Major childhood condition(s):
❑ Chronic pain	❑ Blood condition(s):	❑ Eye condition(s):

❑ Sexually Transmitted Infection(s):	❑ Substance use/abuse:	
❑ Other:		

Are you seeing any specialist for any of the above medical issues? If yes, who?

_____

_____

Do you have any DRUG allergies? Please list them.

1.	2.
3.	4.
5.	6.

Are you on any medication? Please list them.

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

Thank you for taking the time to complete this health questionnaire. It will allow our physicians to gain a full complete history and understand your unique health needs.