NEW PATIENT INFORMATION SHEET

NAME: ______________________________

DATE: ______________________________

WHY ARE YOU SEEING THE DOCTOR TODAY? ______________________________

WHAT IS YOUR MARTIAL STATUS? single married common-law divorced widowed separated # of children ___
(PLEASE CIRCLE)

WHAT IS YOUR OCCUPATION? ______________________________

PAST MEDICAL HISTORY:

1. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING ILLNESSES?

- ☐ HEART ATTACK / ANGINA
- ☐ TIA / STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ DIABETES
- ☐ CROHN'S / ULCERATIVE COLITIS
- ☐ THYROID DISEASE
- ☐ HAEMOCHROMATOSIS
- ☐ HIGH CHOLESTEROL
- ☐ TUBERCULOSIS
- ☐ DEPRESSION
- ☐ OSTEOPOROSIS
- ☐ HEPATITIS
- ☐ PSORIASIS
- ☐ OTHER: ______________________________

2. MEDICAL ALLERGIES ☐ YES ☐ NO

____

____

3. HAVE YOU EVER HAD ANY SURGERIES / OPERATIONS? ☐ YES (PLEASE LIST) ☐ NO

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4. PLEASE LIST ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS YOU ARE TAKING NOW:

MEDICATION NAME	DOSE / AMOUNT	HOW OFTEN

HAVE YOU USED ANY OF THESE:

- ☐ CELEBREX
- ☐ MOBICOX
- ☐ NAPROXEN
- ☐ ARTHROTEC
- ☐ DICLOFENAC
- ☐ ADVIL / MOTRIN / IBUPROFEN
- ☐ INDOCID / INDOMETHACIN
- ☐ VOLTAREN
- ☐ SURGAM
- ☐ FELDENE
- ☐ RELAFEN

5. DO YOU SMOKE CIGARETTES? YES NO # PER DAY _______

6. DO YOU CONSUME ALCOHOL? YES NO # PER WEEK _______