#530, 10333 Southport Road SW
Calgary AB T2W 3X6
403.689.9889

Comprehensive Patient Questionnaire

Part A: General Information & History

Date:

Last Name	First Name	Initials	Age
Street Address			D.O.B. / / dd / mm / yy
City	Province	Postal Code	Gender:
Home: ( )	Work: ( )	Cell: ( )	
Email:	Name of Significant Other:		
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Common-law ☐ Widowed ☐ Other			
Children: Y N	Ages & Sex:		
Occupation: F/T P/T Shift	Place of Employment:		
Emergency Contact:	Phone:		

Family Doctor:	T:
Dentist:	T:
Alberta Healthcare #:	

List all health professionals you are currently under the care of		Reason
Name:	Practice:	
Name:	Practice:	
Name:	Practice:	
Name:	Practice:	

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Current health conditions/concerns: and how long have they been a concern to you, listed in order of importance:

Concern	How Long
1.	
2.	
3.	
4.	
5.	

To what extent do these concerns interfere with your daily activities (work, sleep, etc.)?

Not At All 0 1 2 3 4 5 6 7 8 9 10 Interfere Greatly

Explain:____

How would you rate your general health: Poor 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Excellent

What are your goals for today's visit? -____

____

Past Medical: Check the event (H = hospitalization, S = surgery, T = injury, accident or illness) then list the details

H	S	T	When?	What happened?
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		

Have you ever had general anesthetic? Y N If yes, when?_____________________________________

Allergies: (list all known food, drug, environmental allergies even if they occurred in childhood)

Allergy	First Noticed?	Reaction

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Medications: (list all prescription & over-the-counter)

Medication	Dose	How long?	For What?

Supplements: (list all herbal, nutritional & nutraceutical products)

Supplement	Dose	How long?

Dental: (Please list all dental work, treatments, infections, surgery or appliances excluding regular cleanings)

Date	Treatment

Describe any current dental concerns or symptoms: ____

Antibiotic use:

Date	How Many Courses?	For What?

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Travel: (Please list backcountry, camping & third world trips)

Where	When	Illness or Trauma

Physical Fitness:

Activity	Times/week	Duration	How Long (wks, mo.)

Smoking:

Type	How Often (per day/wk)	How Long (yrs)	Quit – When

Diet:

Are you vegetarian? Y N If yes, what kind? lacto ovo lacto-ovo pesco vegan

Food Group	Servings		Type
	Daily	Weekly	
Vegetables			
Fruits			
Beans & Legumes			
Eggs			
Dairy			
Meat			
Poultry			
Fish			
Grains (bread, pasta, cereal, etc.)			

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Describe your typical meals and food preferences:

Meal	Time	Food / Drink
Breakfast		
Lunch		
Dinner		
Snacks / Dessert		
Drinks	n/a	
Cravings	n/a	
Aversions	n/a	

How long have you been following the diet mentioned above?____

Are there any foods or drinks that you find hard to digest or that aggravate your symptoms? ___________________________________

____

How many glasses of water do you drink a day? ________ What type of water do you drink? ☐ Tap ☐ Spring ☐ Purified

Do you regularly eat or use any of the following:

Item	Frequency per		
	Day	Week	Month
Aluminum cookware/utensils			
Artificial sweetener			
Candy/Chocolate			
Crystal drink powder			
Fried foods			
Lard			
Margarine			
Microwave			
Processed/Deli meats			
Shortening			
Sugar			

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Digestion/Abdomen

Stomach/abdominal pain	Y N P	If yes or past, is it? cramping pricking distending dull	
		other ______________________________	
Above pain relieved by	pressure	hot cold bowel movement	
Trouble swallowing	Y N P	______________________________	
Heartburn	Y N P	______________________________	
Change in thirst	Y N P	______________________________	
Do you prefer	hot drinks	cold drink not thirsty	
Change in appetite	Y N P	______________________________	
If yes or past, describe	abnormal	overeating under eating hungry yet cannot eat	
Taste/Feeling in Mouth	bland sour	salty hot sweet bitter sticky metallic	
Nausea	Y N P	______________________________	
Vomiting	Y N P	______________________________	
Belching/gas/bloating	Y N P	______________________________	
Do these symptoms occur:		during meals 1 hour after meals 2-3 hours after meals	
Heaviness from foods	Y N P	if yes, which? ______________________________	
Liver/gall bladder disease	Y N P	______________________________	
Gall stones	Y N P	______________________________	
High cholesterol	Y N P	______________________________	
Diabetes	Y N P	______________________________	
Ulcers	Y N P	______________________________	
Pain before eating	Y N P	______________________________	
Pain after eating	Y N P	______________________________	
Low blood sugar/hypoglycemia	Y N P	______________________________	
Irritable before meals	Y N P	______________________________	
Tired after eating	Y N P	______________________________	

Distress from fats/greasy foods (nausea, dizziness, headaches)

Y N P ______________________________

Bowel Function

Frequency of bowel movements ______________ x per day/week

Usual time of bowel movements ______________________________

Consistency of bowel movements ☐ Formed ☐ soft ☐ Hard ☐ Pellets ☐ Broken ☐ Diarrhea

Describe: ______________________________

Constipation Y N P ______________________________

Diarrhea & constipation Y N P ______________________________

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Stool hard to pass	Y N P	____________	
Blood in stools	Y N P	____________	
Mucus in stool	Y N P	____________	
Undigested food in stool	Y N P	____________	

Female Reproduction

Age menses began	________					
Date of last menstrual period	________					
Length of menstrual flow	________ days					
Length of complete cycle	________ days					
Regular self breast exam	Y N P	____________				
Date & results of last PAP	____________					
Abnormal PAPs	Y N P	____________				
No. of pregnancies	________					
No. of live births	________					
No. of miscarriages	________					
No. of abortions	________					
Sexually active?	Y N P					
Birth control	Y N P	Types:_-____________				
Spotting between periods	Y N P	____________				
Are cycles regular?	Y N P	If no, please describe: early	delayed	irregular ________		
Pain during intercourse	Y N P	____________				
Cramps	Y N P	____________				
Abnormal vaginal discharge	yellow	white	thick	strong odor	________	
Vaginal Infections	Y N P	____________				
Menstrual flow	normal	heavy	light	________		
Color of flow	normal	bright red	dark red	light red ________		
Consistency of flow	thin	thick	clots	________		
PMS	breast tenderness	moods	water retention	headaches	craving	
	backache	acne	bloating	other ________		
Ovarian cysts	Y N P	____________				
Uterine fibroids	Y N P	____________				
Difficulty conceiving	Y N P	____________				
Menopausal symptoms	Y N P	____________				