PATIENT QUESTIONNAIRE

PERSONAL & CONTACT INFORMATION

NAME: ______________________________

GENDER: ______________ AGE: ______________

DATE OF BIRTH (DD/MM/YY): ______________________

OHIP #: ______________________________

EMERGENCY CONTACT (Name, Relationship, Phone):

____

EXTENDED BENEFITS COVERING DIETITIAN SERVICES? ☐ Yes ☐ No

ADDRESS: ______________________________

CITY, POSTAL CODE: ______________________

PHONE (CELL): ______________________

PHONE (HOME): ______________________

EMAIL: ______________________________

PREFERRED METHOD OF COMMUNICATION:

☐ CELL PHONE ☐ HOME PHONE ☐ EMAIL

OTHER HEALTH CARE PROVIDERS

NAME: ______________ SPECIALTY: ______________ PHONE: ______________

NAME: ______________ SPECIALTY: ______________ PHONE: ______________

NAME: ______________ SPECIALTY: ______________ PHONE: ______________

TOP HEALTH CONCERNS AND GOALS

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

MEDICAL CONDITIONS, SURGERIES, ILLNESSES

EVENT	DATE	OUTCOME

ALLERGIES, SENSITIVIES, INTOLERANCES

SUBSTANCE (FOOD, DRUG, ENVIRONMENTAL, CHEMICAL)	REACTION

FAMILY HISTORY

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

PATIENT QUESTIONNAIRE

MEDICAL HISTORY

GASTROINTESTINAL

CONSTIPATION: ☐ YES ☐ NO
DIARRHEA: ☐ YES ☐ NO
IRRITABLE BOWEL SYNDROME: ☐ YES ☐ NO
FATTY LIVER: ☐ YES ☐ NO
HEPATITIS: ☐ YES ☐ NO
GALLSTONES: ☐ YES ☐ NO
OTHER CONCERNS: ______________________________

DIABETES

VISION IMPAIMENT (RETINOPATHY): ☐ YES ☐ NO
NUMBNESS/TINGLING IN HANDS OR FEET (NEUROPATHY): ☐ YES ☐ NO
INDIGESTION (GASTROPARESIS): ☐ YES ☐ NO
OTHER CONCERNS/COMPLICATIONS: ______________________________

CARDIAC

HIGH BLOOD PRESSURE: ☐ YES ☐ NO
HISTORY OF HEART ATTACK: ☐ YES ☐ NO
ABNORMAL HEART RHYTHM: ☐ YES ☐ NO
VALVULAR PROBLEMS: ☐ YES ☐ NO
STROKE: ☐ YES ☐ NO
HIGH CHOLESTEROL: ☐ YES ☐ NO
OTHER CONCERNS: ______________________________

CANCER

HISTORY OF CANCER: ☐ YES ☐ NO TYPE OF CANCER: ______________ DATE OF DIAGNOSIS: ________

GYNACOLOGICAL

POLYCYSTIC OVARY SYNDROME: ☐ YES ☐ NO
OTHER CONCERNS: ______________________________

SLEEP

REPORTED SNORING: ☐ YES ☐ NO
SLEEP APNEA: ☐ YES ☐ NO

RESPIRATORY

ASTHMA: ☐ YES ☐ NO
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): ☐ YES ☐ NO

VASCULAR

PERIPHERAL VASCULAR DISEASE: ☐ YES ☐ NO
HEADACHES OR MIGRAINES: ☐ YES ☐ NO

RENAL

CHRONIC KIDNEY DISEASE: ☐ YES ☐ NO
KIDNEY STONES: ☐ YES ☐ NO

OTHER

GOUT: ☐ YES ☐ NO
THYROID DYSFUNCTION: ☐ YES ☐ NO
OTHER CONCERNS: ______________________________

MENTAL HEALTH

ANXIETY: ☐ YES ☐ NO
DEPRESSION: ☐ YES ☐ NO

PATIENT QUESTIONNAIRE

CURRENT MEDICATIONS & SUPPLEMENTS – *Prescription drugs, over the counter drugs (aspirin, laxatives, antacids, etc.), birth control pills, herbs, vitamins, minerals, homeopathics, etc.*

NAME	DOSE & FREQUENCY	DATE STARTED	SIDE EFFECTS

SOCIAL HISTORY

OCCUPATION: ______________________________

RELATIONSHIP(S): ______________________________

CHILDREN? ______________________________

RATE LEVEL OF ENERGY (0-10, 10=most energy)______________

CURRENT OR PREVIOUS SMOKING HISTORY? ☐ YES ☐ NO

WEEKLY ALCOHOL INTAKE: ______________________________

EXERCISE? If yes, what forms?______________________________

HOW OFTEN? ______________________________

DIETARY RESTRICTIONS? ______________________________

SOURCES OF STRESS? ______________________________

CIGARETTES/DAY: __________ # YEARS SMOKING: __________

RECREATIONAL DRUG USE? ☐ YES ☐ NO TYPE: __________

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