

Patient Questionnaire Page 1 / 2

Please complete and fax this form toll-free 1.866.896.7099

CanadaRxConnection
www.canadarxconnection.com

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/ Winnipeg / Canada / R3E 3H3
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/ Fax (toll-free) 1.866.896.7099
/ email: info@canadarxconnection.com
/ web: www.canadarxconnection.com

If you have previously filled out a questionnaire,
please indicate if there are any changes:

Y N First Questionnaire

Contact Information (please print clearly)

First Name _____

Last Name _____

Date _____

Address _____

City _____

Email _____

Phone (home) _____

Phone (work) _____

State _____

Zip _____

Primary Physician Name _____

Address _____

Phone _____

Additional Information

Age _____

Height _____

Weight _____

Sex M F

Date of Birth (DMY) _____

Regular Exercise Y N

Do you smoke cigarettes? Y N

Do you drink alcohol? Y N

If yes to either of the above, what type, frequency and duration.
Please indicate in the space below.

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If you answered yes to any of the previous questions please elaborate in the space below (i.e, duration of illness, any treatment or surgery received, amount smoked and for how long.) Please list all medications you are currently using, including the dosage and frequency.

The following disclaimer is an integral part of this patient questionnaire

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Print Name _____

Signature _____

Date _____

Important

Please note It is mandatory to have had a physical examination in the last 12 months to apply for a consultation.

Have you had one? Y N

Patient Family History

- 1) Diabetes, thyroid or other endocrine disorder Y N
- 2) Breast cancer Y N
- 3) Hypertension (high blood pressure) Y N
- 4) Cardiovascular (heart or artery disease) Y N
- 5) Lipid (cholesterol) disorder Y N
- 6) Prostate Cancer Y N
- 7) Other forms of cancer Y N
- 8) Migraine Headaches Y N
- 9) Other illness not previously noted _____

Patient Medical History

- 1) Blood disorders Y N
- 2) Cancer Y N
- 3) Immune disorders Y N
- 4) Poor wound healing Y N
- 5) Edema or excessive fluid retention Y N
- 6) Neurological disorders (stroke, Parkinsons, Alzheimers, etc.) Y N
- 7) Thyroid, diabetes or other endocrine disorder, including insulin resistance Y N
- 8) Any known nutrition deficiency including minerals and electrolytes Y N
- 9) Hyperlipidemia (high cholesterol) Y N
- 10) Upper respiratory disorders Y N
- 11) Lung disorder (i.e., asthma, emphysema) Y N
- 12) High blood pressure Y N
- 13) Heart disease including arteriosclerosis, angina, heart failure or history of heart attack Y N
- 14) Renal or kidney disease Y N
- 15) Liver disease Y N
- 16) Drug allergies Y N
- 17) Orthopedic or muscle disorder, including fracture, joint disorder or carpal tunnel syndrome Y N
- 18) Emotional disorders Y N
- 19) Surgery Y N
- 20) Glaucoma Y N
- 21) Medications used in the last 12 months Y N
If yes, please specify _____

22) Rheumatoid arthritis, lupus, or connective tissue diseases Y N

23) Gastrointestinal Problems (stomach, ulcers, pancreatitis, etc.) Y N