Dr. Lise Maltais ND, FCAH, CBTI
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NEW PATIENT QUESTIONNAIRE

NAME:_____

ADDRESS:_____

CITY_____POSTAL CODE:_____HOME PHONE:_____BUSINESS PHONE:_____

E-MAIL:_____

DATE OF BIRTH: (D)_____(M)_____(Y)_____AGE:_____

HEIGHT:_____WEIGHT:_____OCCUPATION:_____

HOW DID YOU HEAR ABOUT THIS CLINIC?_____

CARE CARD NUMBER:_____

1. MAIN REASON(S) FOR ATTENDING THE CLINIC, IN ORDER OF IMPORTANCE. INDICATE SINCE WHEN YOU ARE EXPERIENCING YOUR SYMPTOMS.

2. MEDICAL DOCTOR'S NAME:_____

3. DO YOU CONSULT OTHER HEALTH CARE PROFESSIONAL? PLEASE LIST:

4. FOR WOMEN ONLY:
DATE OF LAST PAP TEST?_____
(THIS SCREENING TEST IS AVAILABLE THROUGH DR. MALTAIS)

IF OVER 40, DATE OF LAST SCREENING MAMMOGRAM?_____

5. PLEASE LIST DRUGS/MEDICATIONS YOU ARE CURRENTLY TAKING:

6. DO YOU WEAR A MEDICALECT BRACELET? Y N
7. DO YOU HAVE ANY DRUG RELATED ALLERGIES? Y N
8. DO YOU HAVE SCARS AND IF SO WHERE? Y N
9. DO YOU WEAR A PACEPAKER? Y N

10. PLEASE LIST DRUGS/MEDICATIONS YOU WERE TAKING IN THE PAST:

11. PLEASE LIST ALL THE SUPPLEMENTS (VITAMINS, MINERALS ETC.) YOU ARE TAKING:

12. WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD? (PLEASE CIRCLE)

ABCESSES/ALCOHOLISM/ALLERGIES/ANEMIA/ARTHRITIS/ASTHMA/CANCER/CHICKEN POX

COLD SORES/DEPRESSION/DIABETES/EMPHYSEMA/EPILEPSY/GALL STONES/GOITRE/GONORRHEA

GOUT/HAY FEVER/HEART DISEASE/HEPATITIS/HERPES/INFLUENZA/KIDNEY DISEASE/LEUKEMIA

MALARIA/MEASLES/MISCARRIAGE/MONONUCLEOSIS/MUMPS/PARASITES

PELVIC INFLAMMATORY DISEASE/PERITONITIS/PLEURISY/PNEUMONIA/PROSTATITIS/

RECURRENT INFECTIONS/RHEUMATIC FEVER/RUBELLA/SCARLET FEVER1SEXUAL ABUSE/SKIN DISEASE

STREP THROAT/SINUSITIS/SUNSTROKE/STROKE/SYPHILIS/TONSILITIS/TUBERCULOSIS/TYPHOID FEVER

VENERIAL WARTS/WARTS/WHOOPING COUGH/WORMS/YELLOW FEVER

13. PLEASE LIST ALL YOUR INJURIES AND WHEN.

14. ARE THERE ANY OF THE PRECEEDING CONDITIONS AFTER WHICH YOU HAVE NEVER BEEN TOTALLY WELL SINCE OR WHICH HAVE BEEN MORE SERIOUS THAN USUAL?

15. PLEASE LIST ALL THE SURGERIES YOU HAVE HAD AND WHEN:

16. DO YOU (PLEASE CIRCLE)

SMOKE/DRINK ALCOHOL REGULARLY/ DRINK COFFEE/TEA/POP/USE RECREATIONAL DRUGS

17. WHAT VACCINATIONS HAVE YOU HAD? ANY ADVERSE EFFECTS FROM THEM?

18. HAVE YOU LOST ANY WEIGHT LATELY? HOW MANY POUNDS?

19. WHAT EXERCISE DO YOU DO AND HOW MUCH?

20. INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER MAJOR COMPLAINTS HAVE AFFECTED YOUR RELATIVES.

INDICATE: F=FATHER, M=MOTHER, S1=SIBLING 1, S2=SIBLING 2 ETC., PGM=PATERNAL GRAND-MOTHER MGM=MATERNAL GRAND-MOTHER, PA=PATERNAL AUNT, PU=PATERNAL UNCLE ETC...

ALCOHOLISM:

ALLERGIES:

ARTHRITIS:

ASTHMA:

CANCER:

DEPRESSION:

DIABETES:

EPILEPSY:

GONORRHEA:

HAYFEVER:

HEART DISEASE:

MENTAL ILLNESS:

PARALYSIS:

PNEUMONIA:

SKIN DISEASE:

SYPHILIS:

TUBERCULOSIS:

GOUT: