Health Questionnaire

name_____
address_____
email_____
date of birth_____
OHIP #_____ version code_____
(Cell #) _____
(Business #) _____

CARLTON SKIN CLINIC

Please review your information above. If there is any incorrect information, please write in any changes. In order that we may better understand your entire picture, please fill in this form about the state of your health at the present time.

1. List the medications you are allergic to? _____
   None I know of ☐ _____
2. Allergies to Latex, Band-Aids or other medical products? Yes ☐ No ☐
3. Other Allergies _____
   _____
4. Do you have or have you ever had any of the following conditions?

	YES	NO	COMMENTS
Heart problems / Pacemaker / Heart valve problem			
Artificial body part / Joint replacement (surgery date)			
Diabetes, kidney trouble, high blood pressure			
epilepsy, jaundice, lung problems			
Cancer (other than skin cancer)			
Radiation therapy (which body part was treated?)			
Bleeding problem / Healing problem			
hepatitis B, hepatitis C, HIV			
anything else?			

5. Please list all medications/drugs you are currently taking (this includes all non-prescription medications such as Aspirin, Ibuprofen and vitamins). It is not necessary to provide the dosages.

MEDICATIONS	VITAMINS

6. Are you on or have you taken in the past 2 weeks:

	YES	NO	COMMENTS (like the name)
Anticoagulants (which one?)			
Aspirin			
Anti-inflammatory Drugs			
Warfarin			most recent INR value: date:

Continued on the back

Health Questionnaire

7. Have you or any of your family members ever had a reaction to local anesthetics? Yes ☐ No ☐
If yes, please explain: _____

_____

8. Do you have problems with your:

	YES	NO	COMMENTS
Hearing			
Vision			
Walking			
Speech			

9. Do you now or have you in the past year smoked? Yes ☐ No ☐ quit,☐ in year _____
If yes: Number of years _____ Number of cigarettes per day _____

10. Alcohol consumption of more than more than 4 glasses per day?: Yes☐ No ☐

11. do you take antibiotics for dental work? Yes ☐ No ☐

if yes, why? _____

12. Emergency Contact _____ Relationship to patient: _____
Telephone: (cell)_____(home or business)
_____

13. Family Doctor _____ fax # _____

14. Referring Doctor _____ fax #. _____

Nurse Signature _____ Patient Signature _____

Date _____