The Ottawa Clinic Patient Health Questionnaire

Information collected in this questionnaire is strictly confidential and will become part of your medical record.

First Name, Last Name:________________________ Gender:________________
Health card number:__________________________ Expiry:________________
Date of Birth:______________________________ Age:__________________
Address:____
Tel. (main):______________ (Cell):______________ (Work):______________
Next of Kin:_______________________________ Tel.:__________________
Referral physician:__________________________ Family physician:__________
Would you like your family physician notified of this appointment? ☐ Yes ☐ No
Occupation:________________________________ Hobbies:______________
WSIB:____________________________________ Case number:__________
How did you hear about The Ottawa Clinic?_____________________________
How would you prefer to receive appointment confirmations?
Phone________________ Text________________ Email________________
Would you prefer your confirmation in ☐ English or ☐ French?

Reason for this visit:____

Past Surgical History: include procedures and any adverse reactions to surgery (ie.: bleeding, anaesthetic problems, malignant hyperthermia etc):

____
____
____

Medications: List all prescription AND non-prescription medications, vitamins and supplements: Please include Aspirin and blood thinners.

____
____
____

Allergies: medications, latex, surgical tape etc:

Drug:______________________________ **Reaction:**______________________
Drug:______________________________ **Reaction:**______________________
Drug:______________________________ **Reaction:**______________________

Medical History: Do you have, or have you ever had any of the following? Please check all that apply.

☐ Heart problems (heart attack, angina, irregular heart rhythm, high blood pressure, high Cholesterol, heart valve replacement, pacemaker or defibrillator)

☐ Lung problems (breathing problems, asthma, emphysema, COPD, sleep apnea)

☐ Blood issues (bleeding tendencies, family history of bleeding, blot clot, embolism)

☐ Anxiety or emotional disorder

☐ Liver problems (Hepatitis)

☐ Muscle/bone problems

☐ Poor healing/Bad scars

☐ Cancer/Skin Cancer

☐ Digestive problems (Heartburn)

☐ Kidney/bladder problems

☐ Thyroid problems

☐ HIV/AIDS

☐ Other:______________________________

Specific Health questions:

1. Which is your dominant hand? ☐ Right ☐ Left
2. Do you have sleep apnea? ☐ Yes ☐ No If yes do you use CPAP? ☐ Yes ☐ No
3. Do you have diabetes ☐ Yes ☐ No Treatment:______________________
4. Do you have a latex allergy? ☐ Yes ☐ No
5. Do you require antibiotics prior to a surgical procedure? ☐ Yes ☐ No
6. Do you (or anyone in your family) have problems with anesthesia? ☐ Yes ☐ No
7. Are you currently pregnant or trying to get pregnant? ☐ Yes ☐ No
8. Tobacco use (packs per day)__________How long:__________Ex. Smoker: ☐ Yes ☐ No
9. Alcohol use (drinks per day)__________How long:__________

Initials	
	I consent for photographs to be taken if deemed necessary. Photographs will only be used in your records
	I declare that the statements made in this questionnaire are true to the best of my knowledge.

Signature:______________________________________**Date:**__________________________