THE OTTAWA CLINIC
2936 Baseline Road, Suite 102
Ottawa, Ontario K2H 1B3
Phone: 613.232.7777
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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): ___________________________

Email address: ____

Next of Kin: ____ Tel: ____________________________

Family Physician: _____________________________ Referring 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? ____

Would you prefer your confirmation in □ English □ French?

Reason for this visit: ____

____

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

____

____

____

Medications: Please list all prescription and non-prescription medications, vitamins and supplements (please include Aspirin and blood thinners):

____

____

Allergies (medications, latex, surgical tape, etc):

Drug: ____________________________________ Reaction: ______________________________________

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Medical History:

Please list your medical issues:

1.____ 5.____

2.____ 6. ____

3.____ 7.____

4.____ 8. ____

In addition to above, please check all that apply below (if any):

- ☐ 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, blood clot, embolism)
- ☐ Anxiety or emotional disorder
- ☐ Liver problems (hepatitis)
- ☐ Muscle/bone problems
- ☐ Poor healing or bad scars
- ☐ Cancer (including skin cancers)
- ☐ Digestive problems (heartburn)
- ☐ Kidney/bladder problems
- ☐ Thyroid problems
- ☐ HIV/AIDS
- ☐ Other: ____

Details: ____

____

____

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 current pregnant or trying to get pregnant? ☐ Yes ☐ No
8. Tobacco use (packs per day): ________ How long: ________ Ex. Smoker: _________
9. Cannabis use (frequency):___________ How long: ________
10. Alcohol use (drinks per day): ________ How long: ________

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

Signature: ____ Date: _________________________________