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General Thoracic Surgery
General Surgery
Assoc. Clinical Professor of Surgery
- Northern Ontario School of Medicine – Lakehead University

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:		☐ M ☐ F		**DOB:**	
Address				**APT.**	
City				**Postal Code**	
Home Phone		**Cell Phone**		**Work Phone**	
Email Address		**I agree to receive correspondence by email or SMS**		☐ **Yes**	☐ **No**
Family Physician		**Other Care Provider(s)**			
Height		**Weight**			

PERSONAL HEALTH HISTORY

List any diagnosed medical problems

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and inhalers		
Name of Drug	Strength	Frequency Taken

Preferred Pharmacy

Allergies to Medications **NO** ___ **YES** ___ (please list below)	
Name of Drug	Reaction

FAMILY HISTORY OF CANCER (please be as specific as possible)					
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		
Other	☐ M ☐ F		**Other**	☐ M ☐ F	

SMOKING HISTORY	
Have you ever smoked?	☐ Yes ☐ No
If yes, for how long? ________ years in the amount of ______ packs per day	If you have quit smoking, how long ago?__________________