HALIBURTON FAMILY MEDICAL CENTRE

Health Questionnaire

Please fill out one form for each person requesting a physician and return to the HFMC at:
7217 Gelert Road, Haliburton ON K0M 1S0

Last Name_____ First Name_____
Mailing Address_____
City_____Postal Code_____Date of Birth: (D) ____(M)____(Y)_____
Health Card No._____ Version Code (letters at the end)____
Home Phone ( )_____ Work No. ( )_____Cell Number:_____
Email Address_____

Family Member(s) also completing a health questionnaire:

Name & Relationship	Health Card Number	Date of Birth

Medical Problems: *(past and present)*

- ☐ Hypertension/Heart Disease/Stroke
- ☐ Lung Disease/Asthma/Chronic Bronchitis
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Depression/Anxiety
- ☐ Other (please list):
- ☐ Bowel/Stomach Problems
- ☐ Arthritis
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Substance /Tobacco Abuse

Past Surgeries:

Allergies to medications:

Medications: *(including pain medication/past or present)*

****You may attach a recent medication list from your pharmacy or previous health care provider****
Please provide the name of your most recent health care provider:_____Date last seen:_____
Preventive Screening:
Female ⟹ Date of last mammogram: _____Date of last pap:_____Date of last FOBT/Colonoscopy:_____
If you are 65 or over, date of last flu shot:_____

Male ⟹ Date of Last FOBT/Colonoscopy:_____
If you are 65 or over, date of last flu shot:_____

PLEASE CHECK HERE IF YOU HAVE REGISTERED WITH HEALTH CARE CONNECT ☐ **DATE OF REGISTRATION:_____**

Signature: _____ **Date:_____**