ST JOSEPH'S HEALTH CARE LONDON

Affix Label Here

NEW PATIENT INFORMATION SHEET

Date: _____

Why are you seeing the Doctor today? _____

What is your marital status *(circle)?* Single Married Common-law Widowed Divorced Separated

How many children do you have? _____ **What is your Age?** _____

What is your Occupation? _____ **Are you on Disability?** YES ❑ NO ❑

What is your Drug Plan: Private Insurance ❑ Over 65 Government ❑ Ontario Drug Benefits ❑ Other ❑

Past Medical History

1. ***Do you have or have you had any problems relating to your ...?***

Eyes	❑	Throat	❑	Stomach	❑	Muscles	❑
Nose	❑	Heart	❑	Liver	❑	Bones	❑
Mouth/jaw	❑	Chest	❑	Bowels	❑	Joints	❑
Ears	❑	Lungs	❑	Kidneys/Bladder	❑	Nerves	❑
Head/Brain	❑	Thyroid	❑	Pregnancy (miscarriage)	❑		

2. ***Do you have or have you had any of the following illnesses?***

Heart Attack / Angina	❑	Thyroid Disease	❑	Osteoporosis	❑
TIA / Stroke	❑	Haemochromatosis	❑	Hepatitis	❑
High Blood Pressure	❑	High Cholesterol	❑	Psoriasis	❑
Diabetes	❑	Tuberculosis	❑	Other:	
Crohn's / Uclerative Colitis	❑	Depression	❑		

3. ***Have you ever had a Stomach Ulcer or Gastrointestinal Bleeding?*** YES ❑ NO ❑
   a. ***If YES, what year did you have this:*** _____
   b. ***How was it diagnosed:*** Scope ❑ Barium X-ray ❑ Don't Know ❑

4. ***Have you ever had any surgeries/operations?*** YES (please list) ❑ NO ❑

_____ _____
_____ _____
_____ _____

5. **Please list any prescription or non-prescription <u>MEDICATIONS</u> you are taking now:**

Medication Name	Dose/Amount	How Often

<u>What NSAIDs have you tried?</u>

Celebrex	❑
Vioxx	❑
Bextra	❑
Mobicox	❑
Naprosyn	❑
Arthrotec	❑
Advil/Motrin	❑
Indocid	❑
Voltaren	❑
Surgam	❑
Feldene	❑
Relafen	❑

6. ***Do you have any ALLERGIES to Medications?*** YES ❑ NO ❑
   a. ***If YES, please list the medication and describe what happens?***
      i. _____
      ii. _____
      iii. _____

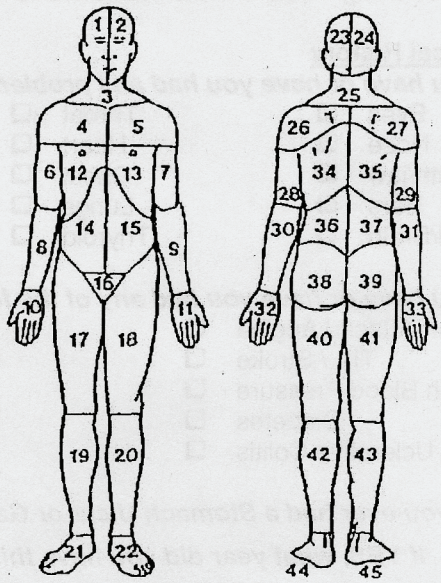
7. ***Do you SMOKE cigarettes?*** Never ❑ Used to, but quit ❑ Yes, still do ❑
   a. ***Number of years smoked:*** _____
   b. ***Number of packs smoked per day:*** _____

8. ***Do you drink Alcohol?*** Never ❑ Yes ❑
   a. ***Number of drinks per week:*** _____

9. ***Do any of your immediate family or distant family relatives have any of the following?***

Rheumatoid Arthritis ❑
Lupus ❑
Gout ❑
Blood clots ❑
Raynaud's Phenomenon ❑
Osteoarthritis ❑
Other types of Arthritis ❑
Psoriasis ❑
Cancer ❑
Bleeding problems ❑
Low Back Pain ❑
Osteoporosis ❑
Heart Disease ❑
Fibromyalgia ❑
Diabetes ❑

10. ***Please shade in the following diagram to show where you have had pain over the past month.***



Thank-You for completing the questionnaire, DO NOT WRITE BELOW THIS LINE

History of Presenting Illness