



# Patient Questionnaire

Please complete and fax this form  
toll-free 1.866.576.7377

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Licence # 32533

/ 2641 St. Mary's Road / Winnipeg / Canada / R2N 4A2  
/ Phone (toll-free) 1.866.571.7377 / Fax (toll-free) 1.866.576.7377  
/ email: info@sdhs.us / web: www.sdhs.us

If you have previously filled out a questionnaire, please indicate if there are any changes:  Y  N  First Questionnaire

### Contact Information (please print clearly)

First Name \_\_\_\_\_ >PDP  
 Last Name \_\_\_\_\_  
 Date \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/Town \_\_\_\_\_  
 Email \_\_\_\_\_  
 Phone (home) \_\_\_\_\_ R2N 4A2  
 Phone (work) \_\_\_\_\_  
 State \_\_\_\_\_  
 Zip \_\_\_\_\_  
 Primary Physician Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_

### Additional Information

Age \_\_\_\_\_  
 Height \_\_\_\_\_  
 Weight \_\_\_\_\_  
 Sex  M  F  
 Date of Birth (DMY) \_\_\_\_\_

Regular Exercise  Y  N  
 Do you smoke cigarettes?  Y  N  
 Do you drink alcohol?  Y  N

If yes to either of the above, what type, frequency and duration. Please indicate in the space below.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Important

**Please note** It is mandatory to have had a physical examination in the last 12 months to apply for a consultation.

Have you had one?  Y  N

### Patient Family History

1) Diabetes, thyroid or other endocrine disorder  Y  N  
 2) Breast cancer  Y  N  
 3) Hypertension (high blood pressure)  Y  N  
 4) Cardiovascular (heart or artery disease)  Y  N  
 5) Lipid (cholesterol) disorder  Y  N  
 6) Prostate Cancer  Y  N  
 7) Other forms of cancer  Y  N  
 8) Migraine Headaches  Y  N  
 9) Other illness not previously noted \_\_\_\_\_

### Patient Medical History

1) Blood disorders  Y  N  
 2) Cancer  Y  N  
 3) Immune disorders  Y  N  
 4) Poor wound healing  Y  N  
 5) Edema or excessive fluid retention  Y  N  
 6) Neurological disorders (stroke, Parkinsons, Alzheimers, etc.)  Y  N  
 7) Thyroid, diabetes or other endocrine disorder, including insulin resistance  Y  N  
 8) Any known nutrition deficiency including minerals and electrolytes  Y  N  
 9) Hyperlipidemia (high cholesterol)  Y  N  
 10) Upper respiratory disorders  Y  N  
 11) Lung disorder (i.e., asthma, emphysema)  Y  N  
 12) High blood pressure  Y  N  
 13) Heart disease including arteriosclerosis, angina, heart failure or history of heart attack  Y  N  
 14) Renal or kidney disease  Y  N  
 15) Liver disease  Y  N  
 16) Drug allergies  Y  N  
 17) Orthopedic or muscle disorder, including fracture, joint disorder or carpal tunnel syndrome  Y  N  
 18) Emotional disorders  Y  N  
 19) Surgery  Y  N  
 20) Glaucoma  Y  N  
 21) Medications used in the last 12 months  Y  N  
 If yes, please specify \_\_\_\_\_

22) Rheumatoid arthritis, lupus, or connective tissue diseases  Y  N  
 23) Gastrointestinal Problems (stomach, ulcers, pancreatitis, etc.)  Y  N

If you answered yes to any of the previous questions please elaborate in the space below (i.e. duration of illness, any treatment or surgery received, amount smoked and for how long.) Please list all medications you are currently using, including the dosage and frequency.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Print Name \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Date \_\_\_\_\_