Confidential Personal History

Date : _____

Name (Last name, first name): _____

Parents Names (if patient is a child): _____

Date of Birth (DD/MM/YY): ___/_____/_____ Age: _____ Sex: _____

Health Card: Number : _____Letters : _____ Expiry: _____

Telephone Number: (Please place a * next to primary # to use)

Home (____) _____ Work (____) _____Cell (_____) _____

Email: _____

Home Address: _____

_____Postal Code _____

Occupation(if adult):_____

Doctor who referred you to Dr Werger or Oyewumi:

_____

Family Doctor (if not referring physician) _____

Number one problem here to see doctor about: _____

List all current medications and dosages and frequency taken :

_____

_____

_____

_____

List all allergies:

Medication allergies _____

_____

Other allergies _____

Have you ever had allergy tests ? YES / NO If yes, when ? _____

****Please turn over .**

Have you ever smoked? Yes ☐ No ☐

If yes then answer the following:

Are you currently smoking : Yes ☐ No ☐ Amount _____ packs/day

Total number of years smoked: _____

If quit, How long ago : _____

Estimate the amount of alcohol per week: _____ Beer _____Wine _____oz liquor

Please answer the following questions to the best of your ability - if you answer yes please explain.

1. Have you ever had any heart troubles? YES ( ) NO ( ) _____
2. Do you have high blood pressure? YES ( ) NO ( ) _____
3. Do you have asthma/Bronchitis/emphysema? YES ( ) NO ( ) _____
4. Do you have diabetes? YES ( ) NO ( ) _____
5. Could you be pregnant? YES ( ) NO ( ) _____
6. Do you have rheumatoid arthritis? YES ( ) NO ( ) _____
7. Do you have any stomach problems or ulcers? YES ( ) NO ( ) _____
8. Have you taken any oral steroid drugs in the last year (not puffer) ? YES ( ) NO ( )
9. Do you need antibiotics before dental work? YES ( ) NO ( ) _____
10. Have you or a member of your family had a problem with an anaesthetic (i.e. malignant hyperthermia)? YES ( ) NO ( ) _____
11. Have you ever been diagnosed or suspected to have sleep apnea? YES ( ) NO ( )
12. Describe any other current medical problems: _____

    _____
13. List previous operations and dates (if related) _____

    _____
14. List previous illnesses: _____

    _____