POLO
HEALTH + LONGEVITY CENTRE

Health History Questionnaire

All information included here will be *absolutely confidential*. If you have any questions please ask. Thank you.

Name_____ Age _____ M ☐ F ☐ Today's Date _____
Your Care Card Number_____ Birthdate (D/M/Y) _____
Home Address _____
_____ Postal Code _____
Occupation _____
Work Phone _____ Home Phone _____
Spouse's Name_____ Children (Name/Age)_____
_____
E-mail Address _____
I give permission to be emailed occasionally about specials or new treatments: Yes or No (circle)

Names of Other Healthcare Providers:
Medical Doctors _____ Naturopathic Physician_____
Chiropractor_____ Others _____

How did you hear about our clinic?
_____

Do you have Extended Coverage? Yes ☐ No ☐ Do you receive MSP Premium Assistance? Yes ☐ No ☐

Your Main Health Concern

What are your main health concerns? Please list in order of importance
1.
2.
3.
4.
5.

When did your problem(s) begin (be specific)?

What is your level of commitment to addressing underlying causes of your symptoms that are related to your lifestyle (10% being 100% committed)
1 2 3 4 5 6 7 8 9 10

Family Medical History

	Age	Health Problems	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Brother/Sisters				
Children				

Your Past Medical History (Please check and date)

☐ Cancer	☐ Diabetes	☐ Venereal Disease
☐ High Blood Pressure	☐ Seizures	☐ Surgeries
☐ Heart Disease	☐ Hepatitis/Kidney Disease	☐ Anemia (All types)
☐ High Cholesterol	☐ Anxiety	☐ Depression
☐ Thyroid Disease	☐ Osteoporosis/Osteopenia	☐ Arthritis
☐ Rheumatic Fever	☐ Asthma	☐ Other Major Illness
☐ Significant Trauma (auto accidents, falls, other)		(Specify) _____
☐ Allergies (drugs, chemicals, environmental, foods)		

(Specify)_____

_____

Current Medications and Supplements

Please list prescriptions, over-the-counter drugs, vitamins and herbs with dose and start date

Social History

How many packs of cigarettes do you smoke a day?

How much alcohol do you drink per week?

Do you take any recreational drugs?

Are you exposed to any toxins or chemicals in your home or work (mold, chemicals, etc)?

Have you been vaccinated?

How often do you exercise?