Pre-physical questionnaire

Name: ______________________________ Today's date: _________________________________
Preferred pronouns: ____

THE INFORMATION PROVIDED IN THIS QUESTIONNAIRE IS USED ONLY BY YOUR PHYSICIAN AND PHYSICIAN'S TEAM AND INFORMATION WILL BE KEPT PRIVATE

Please list any concerns you would like to address today.
1.____
2.____

Any changes in your health? (new diagnoses, new medications, new allergies, hospital visits)
O Yes, Please list ____
O No

Any updates to your family history?
O Yes, Please list ____
O No

Do you have any dietary restrictions? (vegetarian, vegan, gluten free, dairy free etc)
O Yes, Please list ____
O No

Do you use any supplements, vitamins or herbal products?
O Yes, Please list ____
O No

Current guidelines suggest moderate level physical activity for 150 min per week. Are you achieving this regularly?
O Yes I'm getting greater than 150 min/week,
O No I'm getting less than 150 min/week

Broad-spectrum sunscreen (SPF 30 or higher) use is recommended to minimize sun damage. Would you like more information about sun safety? O Yes O No

If applicable, how many drinks of alcohol do you have in a week? ___________(standard drinks/week) (A standard drink is = 12 oz of regular 5% beer, 5 oz of wine, or 1.5 oz spirits)

Have you ever used a tobacco product?
O Yes O No
Do you currently use tobacco products at least once per week? (cigarettes, chewing tobacco etc)
O Yes O No
If yes, how many cigarettes do you smoke per day? _________/day
When was the last year you used a tobacco product (If applicable)? _____________________
How many years did you smoke for in total (cumulative) (If applicable)? __________________
Are you interested in discussing smoking cessation support (If applicable)? OYes O No O N/A

TURN OVER, QUESTIONS CONTINUED ON BACK

Do you use cannabis products?

O Yes, → how many times a week do you use cannabis products?_______ / week
O No

Do you use a vaporizer (ie vape/e cigarettes)?

O Yes, Please list contents_______________________________________
O No

Do you use any other recreational drugs?

O Yes, → how many times a week do you use cannabis products?_______ / week
O No

Are you interested in screening for sexually transmitted infections?

O Yes
O No

Are you doing anything to prevent pregnancy in your sexual encounters?

O Yes, → what method are you using? _______________________________
O No
O Not applicable

If applicable, are you planning to become pregnant in the next year?

O Yes
O No
O Not applicable

If applicable when was the first day of your last menstrual period

O Not applicable
Date ______________________

Do you see your eye doctor every two years?

O Yes
O No

Do you see your dentist every year?

O Yes
O No

I**f > 50 years of age: do you have Power of Attorney, Personal Directive and a Goals of care document (Green sleeve)**

O Yes
O No → Would you like more information? O Yes O No
O Not applicable

Do you have insurance coverage (if yes, list provider)?

O Yes, → please list your provider ______________________
O No

Do you need support from a social worker for help with finances or a safe living environment?

O Yes
O No