

**Dr. Lise Maltais ND, FCAH, CBTI**  
156 Manor Drive, suite 204, Comox BC V9M 1C7  
Phone: (250) 339-4880 Fax: (250) 339-4807  
doveclinic@shaw.ca



## NEW PATIENT QUESTIONNAIRE

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

DATE OF BIRTH: (D) \_\_\_\_\_ (M) \_\_\_\_\_ (Y) \_\_\_\_\_ AGE: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

HOW DID YOU HEAR ABOUT THIS CLINIC? \_\_\_\_\_

CARE CARD NUMBER: \_\_\_\_\_

**1. MAIN REASON(S) FOR ATTENDING THE CLINIC, IN ORDER OF IMPORTANCE. INDICATE SINCE WHEN YOU ARE EXPERIENCING YOUR SYMPTOMS.**

**2. MEDICAL DOCTOR'S NAME:** \_\_\_\_\_

**3. DO YOU CONSULT OTHER HEALTH CARE PROFESSIONAL? PLEASE LIST:**

**4. FOR WOMEN ONLY:**

**DATE OF LAST PAP TEST?** \_\_\_\_\_

*(THIS SCREENING TEST IS AVAILABLE THROUGH DR. MALTAIS)*

**IF OVER 40, DATE OF LAST SCREENING MAMMOGRAM?** \_\_\_\_\_

**5. PLEASE LIST DRUGS/MEDICATIONS YOU ARE CURRENTLY TAKING:**

<b>6. DO YOU WEAR A MEDICALECT BRACELET?</b>	<b>Y</b>	<b>N</b>
<b>7. DO YOU HAVE ANY DRUG RELATED ALLERGIES?</b>	<b>Y</b>	<b>N</b>
<b>8. DO YOU HAVE SCARS AND IF SO WHERE?</b>	<b>Y</b>	<b>N</b>
<b>9. DO YOU WEAR A PACEPAKER?</b>	<b>Y</b>	<b>N</b>

**10. PLEASE LIST DRUGS/MEDICATIONS YOU WERE TAKING IN THE PAST:**

**11. PLEASE LIST ALL THE SUPPLEMENTS (VITAMINS, MINERALS ETC.) YOU ARE TAKING:**

**12. WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD? (PLEASE CIRCLE)**

ABCESSES/ALCOHOLISM/ALLERGIES/ANEMIA/ARTHRITIS/ASTHMA/CANCER/CHICKEN POX

COLD SORES/DEPRESSION/DIABETES/EMPHYSEMA/EPILEPSY/GALL STONES/GOITRE/GONORRHEA

GOUT/HAY FEVER/HEART DISEASE/HEPATITIS/HERPES/INFLUENZA/KIDNEY DISEASE/LEUKEMIA

MALARIA/MEASLES/MISCARRIAGE/MONONUCLEOSIS/MUMPS/PARASITES

PELVIC INFLAMMATORY DISEASE/PERITONITIS/PLEURISY/PNEUMONIA/PROSTATITIS/

RECURRENT INFECTIONS/RHEUMATIC FEVER/RUBELLA/SCARLET FEVER<sup>1</sup>SEXUAL ABUSE/SKIN DISEASE

STREP THROAT/SINUSITIS/SUNSTROKE/STROKE/SYPHILIS/TONSILITIS/TUBERCULOSIS/TYPHOID FEVER

VENERIAL WARTS/WARTS/WHOOPING COUGH/WORMS/YELLOW FEVER

**13. PLEASE LIST ALL YOUR INJURIES AND WHEN.**

**14. ARE THERE ANY OF THE PRECEEDING CONDITIONS AFTER WHICH YOU HAVE NEVER BEEN TOTALLY WELL SINCE OR WHICH HAVE BEEN MORE SERIOUS THAN USUAL?**

**15. PLEASE LIST ALL THE SURGERIES YOU HAVE HAD AND WHEN:**

**16. DO YOU (PLEASE CIRCLE)**

SMOKE/DRINK ALCOHOL REGULARLY/ DRINK COFFEE/TEA/POP/USE RECREATIONAL DRUGS

**17. WHAT VACCINATIONS HAVE YOU HAD? ANY ADVERSE EFFECTS FROM THEM?**

**18. HAVE YOU LOST ANY WEIGHT LATELY? HOW MANY POUNDS?**

**19. WHAT EXERCISE DO YOU DO AND HOW MUCH?**

**20. INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER MAJOR COMPLAINTS HAVE AFFECTED YOUR RELATIVES.**

INDICATE: F=FATHER, M=MOTHER, S1=SIBLING 1, S2=SIBLING 2 ETC., PGM=PATERNAL GRAND-MOTHER  
MGM=MATERNAL GRAND-MOTHER, PA=PATERNAL AUNT, PU=PATERNAL UNCLE ETC...

ALCOHOLISM:

HAYFEVER:

ALLERGIES:

HEART DISEASE:

ARTHRITIS:

MENTAL ILLNESS:

ASTHMA:

PARALYSIS:

CANCER:

PNEUMONIA:

DEPRESSION:

SKIN DISEASE:

DIABETES:

SYPHILIS:

EPILEPSY:

TUBERCULOSIS:

GONORRHEA:

GOUT:

