Dr. E. Lalor

Patient Questionnaire

Name: _____ **Today's Date:**
Date of Birth (day/month/year): **Weight:**
Height:
Health Card **Preferred Pharmacy:**

List all medications that you are <u>currently taking</u> and their dosage:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____ _____

List your Surgical History (and approximate date if known):

_____ _____
_____ _____
_____ _____

List your Medical History (and approximate date of initial diagnosis):

_____ _____
_____ _____
_____ _____

List any <u>Medication Allergies</u>:

_____ _____ _____
_____ _____ _____

Do you smoke? _____ How long? _____ How much per day_____

How many alcoholic drinks do you drink during an average week? _____
(including. wine & beer)

List any Family History (who, which disease, what age diagnosed) of digestive disorders, especially colorectal cancer or polyps, other digestive cancers, uterine or ovarian cancer, and conditions such as reflux, celiac and inflammatory bowel disease (Crohns and ulcerative colitis):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

<u>Email address:</u> _____

Email/virtual care consent: I have reviewed the brief article on virtual care, on the practice website, and consent to being contacted by telephone or email.

Signature: