MEDIGROUP
HEALTH CENTRE

Medigroup Health Centre & Pharmacy
Telephone: 204-410-5200 | Clinic Fax: 204-410-5177 | Pharmacy Fax: 204-410-5188
Clinic Email: mhc@medigroup.ca | Pharmacy Email: mhcp@medigroup.ca
14 - 1585 Kenaston Blvd | Winnipeg, MB R3P 2N3

For office use	
Date:	Time:

Patient Questionnaire

Please fill out the following questionnaire to your best knowledge and bring this to your appointment.

Patient name: first name ______________________________ last name ______________________________

DOB: day ________________ month ________________ year ________________________________

MH #: ___________________________________ PHIN #: ___________________________________

Address: ____

Phone: home/cell __________________________ work ______________________________________

Email: ____

Next of Kin: ________________________Relationship_____________________Phone#____________________

Private Insurance: ____

Other health professionals: ____

Pharmacy: ☐ Medigroup Health Centre Pharmacy

☐ other: ____

Medical History: please list all previous and current health issues, including all surgeries

1. ____ 4. ____

2. ____ 5. ____

3. ____ 6. ____

Medications: please list all current prescriptions and non-prescription medications

1. ____ 4. ____

2. ____ 5. ____

3. ____ 6. ____

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Allergies:	Reactions:
1. ____	1. ____
2. ____	2. ____
3. ____	3. ____

Family history: please indicate past and current history

Father: ☐ alive _______ years of age
☐ deceased _______ years of age

Mother: ☐ alive _______ years of age
☐ deceased _______ years of age

Hypertension	☐ No	☐ Yes	Who______________	Age_________
Cancer	☐ No	☐ Yes	Who______________	Age__________
Stroke	☐ No	☐ Yes	Who______________	Age __________
Heart Attack	☐ No	☐ Yes	Who______________	Age __________
Diabetes	☐ No	☐ Yes	Who______________	Age__________

Other ____

Lifestyle/Social History:

Marital Status	☐ Married	☐ Single ☐ Divorced ☐ Common-Law ☐ Other		
Smoking	☐ Never	☐ Ex-smoker Quit when__________	☐ Current	
Exercise	☐ No	☐ Yes How often____		
Alcohol	☐ No	☐ Yes Drinks per day_________	Drinks per week____________	
Marijuana	☐ No	☐ Yes Amount____		
Street Drugs	☐ No	☐ Yes ____		