Dr. Ivan Shcherbatykh, MD, MPH, CCFP
Dr. Julia Shcherbatykh, MD, CCFP
www.charingcrossmedical.com

CHARING CROSS MEDICAL
124 Charing Cross St., Brantford, ON N3R 2J1
Phone: (519) 304-8550 Fax: (519) 304-8554

NEW PATIENT HEALTH QUESTIONNAIRE

Welcome to our practice!

Please take a moment to complete this form to the best of you knowledge and bring back to the office. All information below will be treated in a strictly confidential manner. If enrolled into the practice, it will become part of your medical record and will help Dr. Shcherbatykh and other team members to provide you with the best health care possible.

Today's date: _____

I. Patient Information

Name: _____ Sex: ☐ M ☐ F

Date of birth: (mm/dd/yyyy): _____

Marital status: Married, Single, Divorced, Separated, Other (*please circle*)

Address: _____ Home phone: _____

_____ Work: _____

_____ Mobile: _____

Health card #_____ Previous Doctor: _____

Emergency contacts

Name: _____Relationship: _____Phone: _____

Do you have a ☐ Do Not Resuscitate Order (DNR)? ☐ Power of Attorney for Personal Care?

II. Medical History

Allergies (medications, food, seasonal/environmental, latex, other):

Allergic to: _____ Reaction: _____

_____ _____

_____ _____

Current Health Concerns (e.g., high blood pressure, pain, low mood)

_____

_____

_____

_____

Dr. Ivan Shcherbatykh, MD, MPH, CCFP
Dr. Julia Shcherbatykh, MD, CCFP
www.charingcrossmedical.com

CHARING CROSS MEDICAL
124 Charing Cross St., Brantford, ON N3R 2J1
Phone: (519) 304-8550 Fax: (519) 304-8554

Past Medical History *(please include year of diagnosis)*

Heart conditions _____

(e.g., chest pain, heart attack, high blood pressure, high cholesterol, irregular heart beat)

Lung conditions _____

(e.g., asthma, emphysema/COPD, sleep apnea, lung cancer)

Blood disorders _____

(e.g., anemia, blood clots, hemophilia, blood cancer)

Stomach/bowel _____

(e.g., heartburn, ulcers, Crohn's disease, constipation, bleeding, cancer)

Endocrine conditions _____

(e.g., thyroid disease, diabetes)

Nervous system disease_____

(e.g., migraines, seizures, stroke, memory loss, blackouts)

Infections _____

(e.g., HIV/AIDS, hepatitis, meningitis, tuberculosis, sexually transmitted infections)

Mental health _____

(e.g., depression, anxiety, psychosis, bipolar disease, suicidal thoughts, alcohol abuse)

Other _____

_____

(e.g., cancer, arthritis, fractures, osteoporosis, irregular periods, erectile dysfunction)

Past Surgeries or Hospitalizations *(please include year and reason for hospitalization)*

1. _____
2. _____
3. _____
4. _____

Pregnancy History and Women's Health *(for females only)*

Pregnancies ____ # Deliveries: vaginal ___ c-section___ # Miscarriages ___ # Abortions ___

Date of last Pap smear _____ Date of last mammogram _____

Last bone density test _____ Date of last full physical _____

Dr. Ivan Shcherbatykh, MD, MPH, CCFP
Dr. Julia Shcherbatykh, MD, CCFP
www.charingcrossmedical.com

CHARING CROSS MEDICAL
124 Charing Cross St., Brantford, ON N3R 2J1
Phone: (519) 304-8550 Fax: (519) 304-8554

Medications *(including prescription, vitamin and herbal supplements)*

Medication Dose, mg Times per day Reason

_____

_____

_____

_____

_____

Family History of (*record relationship: mother, father, sister/brother, grandparents, children*)

Heart attack _____ Stroke _____

Diabetes _____ High blood pressure _____

High cholesterol _____ Seizures _____

Dementia _____ Psychiatric conditions _____

Cancer (*specify type*) _____

Other _____

Social history

Occupation _____

Do you smoke? ☐ Yes ☐ Quit (year) ____ ☐ No **If Yes** Cigarettes Cigars Pipe *(circle)*

How many cigarettes/packs a day? _____

How many years? _____ # quit attempts _____

Do you drink alcohol? ☐ Yes ☐ No **If Yes**, # of drinks per week _____

Have you ever used recreational drugs? ☐ Yes ☐ No **If Yes**, which drugs _____

Do you have a special diet? _____

Immunizations history*:* please bring your immunization records to your first appointment

Current medical specialists *(please include name, type of specialist and date of last visit)*

_____

_____

Please provide any other relevant information _____

_____

Thank you,
Charing Cross Medical team