NEW PATIENT
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	◯ M ◯ F	**DOB:**
Address:	**State:**	**ZIP:**
Phone Number:	**Email:**	
Previous Doctor:		

PERSONAL HEALTH HISTORY

Chief Complaint: Reason for visit	
List any medical problems that other doctors have diagnosed	
List current medications: (Prescription, OTC, Herbal supplements, or Recreational drugs)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
Tobacco and Alcohol use: ☐ Tobacco ☐ Alcohol	**Allergies to Medications**:

Payment information		
Credit Card	Number	Expiry

What have you previously tried for disease management: (Diet, Exercise, Medication, Etc.)	
1.	4.
2.	5.
3.	6.

ADDITIONAL INFORMATION

Notes:

Form completed by:

Please send all completed forms to:
Email: orders@bisondrugspharmacy.com
Fax: 204-582-8856
Mail: Bison Drugs Pharmacy
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Winnipeg MB, R2W 3V4