

Anti-Aging Medical & Laser Clinic

2482 West 41st Avenue

Vancouver

British Columbia

(Family Practice, Anti-Aging and Acupunctre certified)

Email: info@antiagingvancouver.com

www.antiagingvancouver.com

Confidential Medical Questionnaire

Demographic Details

Provided for consultation to Anti-Aging Medical & Laser Clinic
**Please be so kind to notify us if any of your details change.

Surname: _____
First Name: _____ Initials: ____
Nick name or how do you prefer to be called? _____
MSP number: _____
Date of birth: mm__/dd__/yyyy_____

Vital Contact Information

Mailing address: _____ Postal City: _____
Postal Code: _____
Email: _____@_____
Give permission to use this email address for personal information: signature _____

Telephone numbers:

Home: _____ Work: _____
Mobile: _____ Emergency: _____
Emergency Contact Person: _____

Medical Contacts

Family Physician: _____
Physician phone number: _____
Specialists/alternative-medical persons involved in your care:
a) Name: _____ Phone: _____
b) Name: _____ Phone: _____

If you have more please add them to the end of this report.

* Indicate if you want Report copies to be mailed to another doctor

Current Occupation: _____ Employment: _____

Marketing

How did you hear about the Anti-Aging Medical and Laser Clinic?

Cancellation Policy

I am aware that Anti-Aging Medical and Laser Clinic has an active cancellation and no show policy. Dr Frame reserves valuable time especially for you.

Initial: __\$100 No Show Fee

__\$50 Cancellation Fee, if cancelled within 24 hour grace period. This fee must be paid prior to a new appointment being made.

Signed _____ Date _____

MEDICAL HISTORY

ILLNESSES PAST & PRESENT			
	DATES	DETAILS	
HIGH BLOOD PRESSURE			
STROKE			
DIABETES			
CANCER			
ALZHEIMER'S DISEASE			
EAR, NOSE, THROAT			
DIGESTIVE SYSTEM Includes ulcers, lactose intolerance, colitis, diverticulitis, IBS			
LUNG DISEASE Eg recurrent pneumonia, bronchitis, athma, emphysema			
HEART DISEASE			
LIVER DISEASE Eg. Gall stones, hipatitis, cirrhosis			
KIDNEY DISEASE Eg. Recurrent infections & stones			
PROSTATE OR GYNECOLOGICAL			
HORMONE ISSUES Eg. Thyroid, menopause and andropause.			
NEUROLOGICAL DISORDERS			
PSYCHIATRIC PROBLEMS Eg depression, anxiety, panic attacks, psychosis			
MUSCLE, BONE & JOINT DISORDERS			
GENERALIZED DISEASE Eg lups, AIDS. Chronic fatigue syndrome, aenemia			
ALCOHOLISM			
ADDICTIONS			
OTHER GENETIC PROBLEMS			
PSYCHIATRIC PROBLEMS: Eg. Depression, anxiety, panic attacks, psychosis			

HEALTH MAINTENANCE

PROVIDE DATES OF MOST RECENT

COMPLETE PHYSICAL EXAM:
OCCULT STOOL BLOOD TEST:
SIGMOIDOSCOPY:
COLONOSCOPY:
CHOLESTEROL:
DIABETES:

FEMALE

PAP SMEAR:
MAMMOGRAM:
MONTHLY BREAST SELF EXAM?
YES ___ NO ___
LAST MENSTRUAL PERIOD:
HYSTERECTOMY AGE:

MALE

RECTAL OR PROSTATE EXAM:
GENITAL OR SELF EXAM:

PREVIOUS COMPREHENSIVE WELLNESS EXAM OR PROGRAM?

SOCIAL HISTORY & RISK FACTORS

MARITAL STATUS

PAST: _____

PRESENT: _____

LEVEL OF EDUCATION:

OCCUPATIONS _____

PAST: _____

PRESENT: _____

RISK FACTORS

TOBACCO

NEVER	CURRENT	PREVIOUS	YEARS SINCE
_____	_____	_____	_____

CURRENTLY SMOKE _____ CIGARETTES PER DAY

CURRENTLY SMOKE _____ PER DAY

ALCOHOL

NEVER	CURRENT	PREVIOUS	YEARS SINCE
_____	_____	_____	_____

CURRENTLY DRINK _____ GLASSES OF WINE PER DAY

CURRENTLY DRINK _____ PER DAY

DRINKS PER WEEK _____ TYPE _____

EXERCISE

NEVER	CURRENT	PREVIOUS	YEARS SINCE
_____	_____	_____	_____

AEROBIC _____ PER WEEK

STRETCHING _____ PER WEEK

WEIGHTS _____ PER WEEK

GYM MEMBERSHIP: _____

PERSONAL TRAINER: _____

ANTHROPOMORPHIC DETAILS

WEIGHT KG/ LB

HEIGHT

DO YOU CONSIDER YOURSELF _____ OVERWEIGHT _____ UNDERWEIGHT

IF SO, BY HOW MUCH?

BODY TYPE: _____ SMALL _____ MEDIUM _____ LARGE

PSYCHOSOCIAL EVALUATION

DESCRIBE CURRENT DIET

___ VEGETARIAN ___ LOW FAT ___ HIGH PROTEIN ___ GOURMET

___ FAST FOOD ___ LOW CARB ___ DIABETIC ___ WEIGHT LOSS

PREVIOUS DIET ATTEMPTS: (SUCCESS?)

ESTIMATE THE FOLLOWING:

SERVINGS PER DAY

FRUIT _____ GREEN VEGETABLES _____

FIBRE FOODS _____ DAIRY PRODUCTS _____

KINDLY KEEP A FOOD DIARY LISTING ALL FOOD EATEN ON **TWO** AVERAGE DAYS. ESTIMATE EACH PORTION SIZE OR AMOUNT, EG 1 CHICKEN BREAST IS THE SIZE OF YOUR PALM.

PLEASE BRING THIS DIARY WITH YOU TO YOUR NEXT CONSULT.

PSYCHOSOCIAL EVALUATION

DESCRIBE ANY STRESSFUL EVENTS IN THE PREVIOUS YEAR (EG DEATH, SEPARATION, FINANCIAL STRESS, LEGAL CONCERNS, OCCUPATIONAL STRESS, SCHOOL OR OTHER)

HOURS OF SLEEP PER NIGHT _____

HOURS OF WORK PER WEEK _____ REGULAR SHIFT HOURS? _____

VACATION PER YEAR _____ WEEKS

NUMBER OF CLOSE FRIENDS _____

NUMBER OF PEOPLE LIVING IN YOUR HOUSEHOLD _____

MEMBER OF SOCIAL OR RELIGIOUS ORGANIZATION YES/NO

STRESS MANAGMENT PROGRAMMES (EG YOGA, MEDITATION, MUSIC)

RISK BEHAVIOUR A)

WEAR A SEAT BELT (PASSENGER OR DRIVER)

_____ ALWAYS _____ SOMETIMES _____ NEVER

DRINK AND DRIVE

_____ ALWAYS _____ SOMETIMES _____ NEVER

DRIVE WITH A DRIVER WHO HAS BEEN DRINKING

_____ ALWAYS _____ SOMETIMES _____ NEVER

LENGTH OF COMMUTE - MINUTES PER DAY _____

ACCIDENTS IN LAST FIVE YEARS _____

SIZE OF VEHICLE

_____ COMPACT _____ MID SIZE _____ LARGE
_____ VAN _____ TRUCK _____ MOTORCYCLE

RISK BEHAVIOUR B)

SUNTANNING HISTORY:

UNPROTECTED SEX

_____ ALWAYS _____ SOMETIMES _____ NEVER

_____ CURRENT _____ PREVIOUS

NUMBER OF LIFETIME SEXUAL PARTNERS _____

SMOKE ALARMS OR SPRINKLER IN THE HOME _____ YES/NO

GUN OWNERSHIP _____ YES/NO

TYPE OF SPORTS (SPECIFY IF REGULAR OR OCCASSIONAL)

PROTECTIVE GEAR OR HELMET WORN _____ YES/NO

Anti-Aging Medical & Laser Clinic
 2482 West 41st Avenue Vancouver British Columbia
 604 261 9121
 (MEDICAL DIRECTOR: DR GIDON FRAME)

Systematic Questionnaire

Rate on scale of 0-5 (0= never, 3=often, 5=servere)

Losing Hair	0	1	2	3	4	5
Problems focusing eyes	0	1	2	3	4	5
Face Rashes	0	1	2	3	4	5
Hearing Loss	0	1	2	3	4	5
Nose Bleeds	0	1	2	3	4	5
Indigestion or heart burn	0	1	2	3	4	5
Swallowing problems	0	1	2	3	4	5
Shortness of breath	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Chest Pain	0	1	2	3	4	5
Abdominal Pain	0	1	2	3	4	5
Diarrhea	0	1	2	3	4	5
Constipation	0	1	2	3	4	5
Passing gas	0	1	2	3	4	5
Yeast infection	0	1	2	3	4	5
Urinary problems	0	1	2	3	4	5
Nail problems	0	1	2	3	4	5
Difficulty exercising	0	1	2	3	4	5
Back or neck problems	0	1	2	3	4	5
Joint pain, muscle weakness	0	1	2	3	4	5
Low energy	0	1	2	3	4	5
Sadness	0	1	2	3	4	5
Sleep problems	0	1	2	3	4	5
Poor concentration	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Anger	0	1	2	3	4	5
Irritability or nervousness	0	1	2	3	4	5
Weight loss	0	1	2	3	4	5
Weight gain	0	1	2	3	4	5
Swollen fees, wrists or ankles	0	1	2	3	4	5
Poor skin healing	0	1	2	3	4	5
Skin tears easily	0	1	2	3	4	5
Swollen glands	0	1	2	3	4	5
Recuurent colds and infections	0	1	2	3	4	5
Prolonged infections	0	1	2	3	4	5
No antibiotic courses (last 12 months)	0	1	2	3	4	5

Anti-Aging Medical & Laser Clinic
2482 West 41st Avenue Vancouver British Columbia
604 261 9121
(MEDICAL DIRECTOR: DR GIDON FRAME)

