PRACTITIONER CONSULTATION - MEDICAL QUESTIONNAIRE

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PERSONAL INFORMATION
First Name: _____ Last Name: _____
Sex: ☐ M ☐ F
Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Wid. ☐ Other _____
Street: _____ Unit # _____ City: _____ State/Prov: _____ Country: _____ Postal Code: _____
Home phone: _____ Cell phone: _____
5. Email address: _____
6. Date of birth: (day/month/year) _____
7. Family contact (e.g. spouse, parent, sibling) Name: _____ Relationship: _____ Contact number: _____
10. Second language (optional): _____
11. Religion (optional): _____

Revised Dec 25, 2025

RECENT HISTORY

Diagnosis of current health problem: ☐ Unknown

How was it diagnosed? Diagnosis date:

Treatments received:

Medication	☐ Yes	☐ No	☐ Not yet, starting soon	☐ Not sure
Surgery	☐ Yes	☐ No	☐ Not yet, soon	☐ Not sure
Natural Therapy	☐ Yes	☐ No	☐ Not yet, starting soon	☐ Not sure
Experimental Therapy	☐ Yes	☐ No	☐ Not yet, starting soon	☐ Not sure
Radiation Therapy	☐ Yes	☐ No	☐ Not yet, starting soon	☐ Not sure

Other:

DETAILS

Please describe ***briefly*** what happened that led to the diagnosis.

Please describe ***briefly*** the sequence of treatment(s), response(s), recurrent problem(s) etc.

PAST HEALTH Do you have (or have you ever had) any of the following? *(check if yes)*

Condition		√	About when was it diagnosed?
Cardiovascular Disease	High blood pressure	☐	
	Angina	☐	
	Heart attack	☐	
	Heart failure	☐	
	Abnormal heart rhythm	☐	
	Blood clot (DVT)	☐	
	High cholesterol	☐	
	Other: specify	☐	
Lung Disease	Asthma	☐	
	Bronchitis / pneumonia	☐	
	Emphysema	☐	
	Other: specify	☐	
Kidney Disease	Stones	☐	
	Infections	☐	
	Kidney failure	☐	
	Other: specify	☐	
GI Disease	Stomach / duodenal ulcer	☐	
	Diverticulitis	☐	
	Reflux / heartburn	☐	
	Irregular bowels	☐	
Liver Disease	Hepatitis	☐	
	Jaundice (yellow eyes/skin)	☐	
	Other: specify	☐	
Neurological Disease	Stroke	☐	
	Seizures	☐	
	Other: specify	☐	
Endocrine Disease	Diabetes, Type 1	☐	
	Diabetes, Type 2	☐	
	Thyroid disease (specify)	☐	
	Adrenal disease (specify)	☐	
	Testicular / ovarian disease	☐	
	Other: specify	☐	

PAST HEALTH Do you have (or have you ever had) any of the following? *(check if yes)*

Problem		√	When?
Skin Disease	Eczema	☐	
	Hives	☐	
	Other:	☐	
Dental Procedures	Root canal(s)	☐	
	Metal ("Silver") Filling(s)	☐	
	Implant(s)	☐	
	Other: specify	☐	
Traumas	Physical / Injury	☐	
	Psychological	☐	
	Sexual	☐	
	Other: specify	☐	
Toxin exposure	Pesticides/herbicides	☐	
	Chemicals	☐	
	Metals	☐	
	Other: specify	☐	
Psychological Issues	Depression	☐	
	Anxiety	☐	
	Phobia	☐	
	Stress	☐	
	Other:	☐	
Sexual Issues	Erectile problem	☐	
	Menstrual problem	☐	
	Infertility	☐	
	Other:	☐	
Prostate Disease		☐	
Urinary Disease		☐	
Cancer (specify type):		☐	
Painful scars		☐	
Problems related to computer use		☐	

Other Health Problems and Surgeries	Approximate date(s)
Problems after **vaccine** or **medication**?	
Received COVID-19 vaccine(s)? ☐ Yes ☐ No	

SOCIAL HISTORY

Occupation

Have you ever smoked cigarettes? ☐ Yes ☐ No
How long? _____ years
How much? _____ per day
Are you still smoking now? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No
If yes, how much?
_____ drinks per day OR _____drinks per week OR ☐ occasionally

Have you ever used recreational drugs? ☐ Yes ☐ No
If yes:
Please list: _____

MEDICATIONS – CONVENTIONAL and NATURAL

Please list all of your **current medications and supplements** (name, dose and how often you take them). If you are not sure of the dose, please just list the name(s).

Name	Dose	How often

ALLERGIES / ADVERSE REACTIONS

Have you ever had an **allergy** or **adverse reaction** to any of the following?

Category	Yes √	No √	Please list
Drugs	☐	☐	
Foods	☐	☐	
Others (pollen, grass, pets, etc.)	☐	☐	

FAMILY HISTORY

Please provide the following information regarding blood relatives

Relation	List major illness (e.g. diabetes, cancer, ulcers, blood clots, heart, lung, liver, kidney disease, immune disease)
Father	
Mother	
Sisters	
Brothers	
Children	☐ Not applicable How many boys? _____ How many girls? _____
Other	

ACTIVITY LEVEL

Please check one:	√
Fully active, able to carry on all activities (same as before cancer diagnosis) without restriction.	☐ 0
Restricted in strenuous activity but walking and able to carry out light work e.g. office work.	☐ 1
Walking and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of the day.	☐ 2
Capable of only limited self-care (washing, changing clothes, going to washroom), confined to bed or chair more than 50% of the day.	☐ 3
Completely disabled. Cannot carry on any self-care (washing, changing clothes, going to washroom). Totally confined to bed or chair.	☐ 4

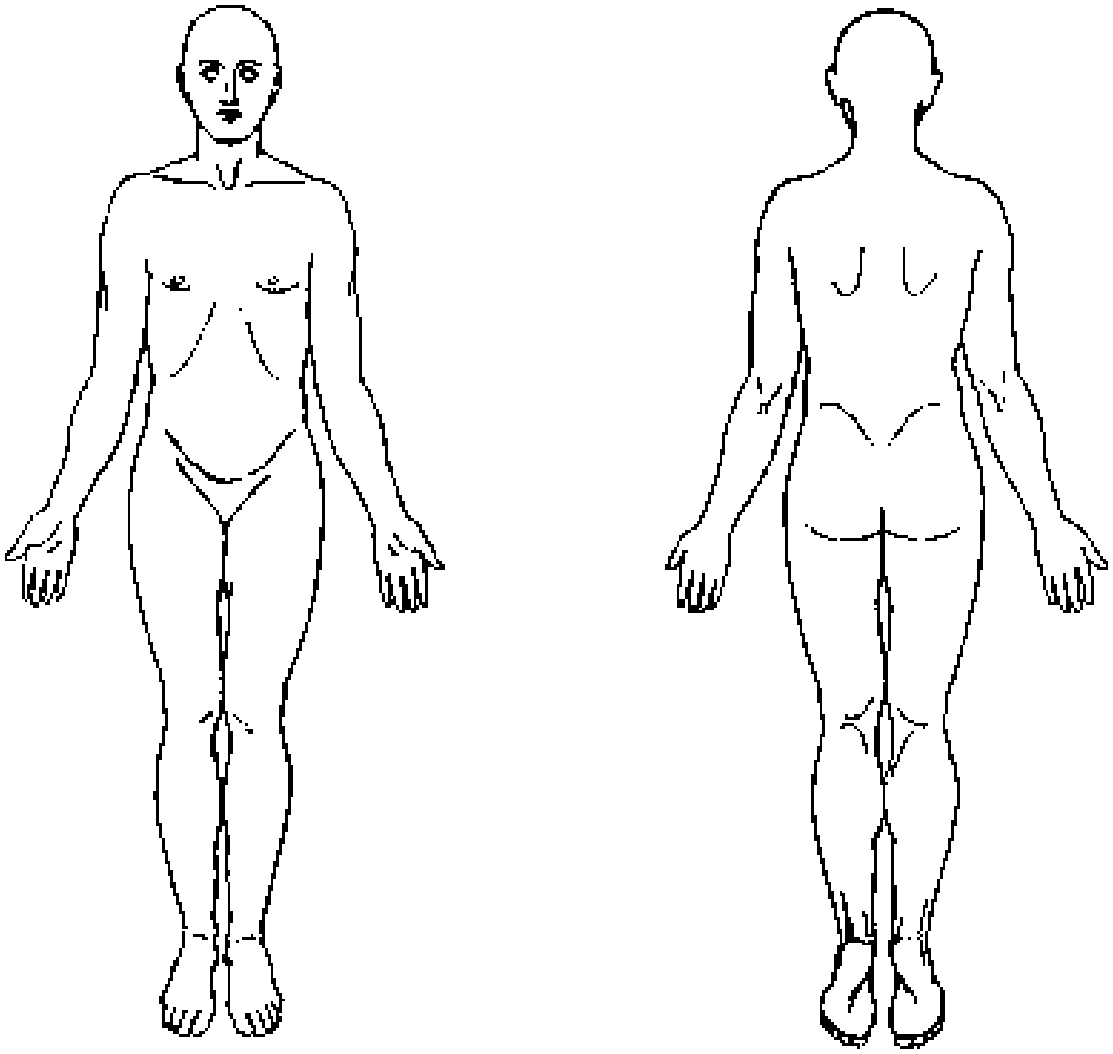
PAIN

Draw areas of pain on the body diagram ☐ Not applicable

Pain #1:
Dull / Sharp / Aching / Burning / Stabbing / Cramping / Throbbing / Tingling / Sensitive / Numb
Intensity of pain (0 = no pain, 10=worst pain ever) 0 1 2 3 4 5 6 7 8 9 10
Constant or intermittent?
What makes the pain worse?_____better?_____

Pain #2:
Dull / Sharp / Aching / Burning / Stabbing / Cramping / Throbbing / Tingling / Sensitive / Numb
Intensity of pain (0 = no pain, 10=worst pain ever) 0 1 2 3 4 5 6 7 8 9 10
Constant or intermittent?
What makes the pain worse?_____better?_____

Pain #3:
Dull / Sharp / Aching / Burning / Stabbing / Cramping / Throbbing / Tingling / Sensitive / Numb
Intensity of pain (0 = no pain, 10=worst pain ever) 0 1 2 3 4 5 6 7 8 9 10
Constant or intermittent?
What makes the pain worse?_____better?_____



SYMPTOM LIST

Height: _____ ft _____ in **or** _____cm Body weight: _____ ☐ pounds ☐ kg

Weight	decreasing	☐5	☐4	☐3	☐2	☐1	☐normal	☐1	☐2	☐3	☐4	☐5 increasing
Appetite	decreased	☐5	☐4	☐3	☐2	☐1	☐normal	☐1	☐2	☐3	☐4	☐5 increased
Sleep	decreased	☐5	☐4	☐3	☐2	☐1	☐normal	☐1	☐2	☐3	☐4	☐5 increased
Mood	depressed	☐5	☐4	☐3	☐2	☐1	☐normal	☐1	☐2	☐3	☐4	☐5 elevated
Energy level	decreased	☐5	☐4	☐3	☐2	☐1	☐normal	☐1	☐2	☐3	☐4	☐5 increased

Do you have any of the following:	Check a box √ (0=none, 10=worst)
Fever	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Sweating	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Nausea	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Vomiting	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Food or liquid sticking when swallowing	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Pain when swallowing	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Constipation	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Diarrhea	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Cough	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Shortness of breath	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Dizziness	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Palpitations (feeling of abnormal heartbeat)	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Limb swelling ☐ legs ☐ arms	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Facial swelling	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Headache	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Numbness / tingling of hands or feet	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Any other parts of the body? (if yes, please list):	
Restlessness	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Confusion	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Memory problems	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Skin Rash	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Bleeding problems / bruising	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Urination problems	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Sexual problems	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

MISCELLANEOUS

Are you or do you think you may be pregnant? ☐ Not applicable ☐ Yes ☐ No

Are you receiving nursing care at home? ☐ Yes ☐ No ☐ Not sure

Do you have a "power of attorney" for:

Personal care? ☐ Yes (name: _____) ☐ No ☐ Not sure

Finances? ☐ Yes (name: _____) ☐ No ☐ Not sure

PRACTITIONER INFORMATION

Please provide the following information about your health care providers:

Name	Email	Specialty

Main licensed practitioner who Dr. Khan will be working with **(required)**:

Name: _____ Specialty: _____

Phone: _____ Fax: _____

Email: _____

NEOS MEDICAL

How did you find out about us?

_____

Thank you for providing this important information.

Signature: _____ **Date:** _____