PEAK GIM QUESTIONNAIRE

DEMOGRAPHICS & FAMILY HISTORY

Your age, sex, ethnicity, occupation and family history can change the risk of you having certain diseases. It is important for us to know this to be as precise as we can be with your care.

Do you have a first degree relative with early onset heart, stroke or blood vessel disease? (men less than 55, women less than 65)	
Has a first degree relative been diagnosed with any of the following (select all that apply)?	☐ Diabetes ☐ Obesity ☐ Cholesterol Problems
What is or was your main occupation?	
What was the sex assigned to you at birth?	
What is your predominant ethnicity?	

PEAL MEDICAL HISTORY

Your family doctor will have most of this information, but it's important we are complete.

Have you ever been told you have any of the following health problems (select all that apply)

- ☐ Cholesterol or lipid disease
- ☐ Heart disease
- ☐ Stroke
- ☐ Blood vessel or vascular disease
- ☐ Aortic disease
- ☐ High blood pressure (hypertension)
- ☐ Diabetes
- ☐ Complications from diabetes
  - ☐ Eyes
  - ☐ Nerves
  - ☐ Kidneys
- ☐ Kidney Disease
- ☐ Obesity
- ☐ Autoimmune or rheumatologic diseases
- ☐ HIV infection
- ☐ Pregnancy related disease
  - ☐ Pre-eclampsia/eclampsia
  - ☐ Gestational diabetes
  - ☐ Gestational hypertension
- ☐ Liver disease
- ☐ Biliary disease
- ☐ Thyroid disease

Have you been treated for any of these conditions outside of Canada?	☐ No ☐ If yes, please contact the clinic to ensure we obtain your records prior to your appointment, if available.

MEDICATIONS

Please list the current pharmacy you use to fill your prescriptions:	

Please list all of your current medications and dosages	

Use this line to list all of your current medications and dosages:

Have you previously been on a cholesterol lowering medicine and had to come off due to side effects?

☐ No ☐ If yes

What drug(s)?

What side effects?

Have you previously been on a diabetes medication and had to come off due to side effects?

☐ No ☐ If yes

What drug(s)?

What side effects?

Do you have any allergies to medications?

☐ No ☐ If yes

What drug(s)?

What side effects?

SOCIAL HISTORY

Any current or past history of smoking, alcohol or other substances can impact how we treat you.

Do you currently or have you ever consumed alcohol?

☐ No ☐ If yes

What kind of alcohol do you usually drink (beer, wine, spirits)?

How many drinks do or did you have in an average week?

How many years have you consumed alcohol?

Do you currently or have you ever smoked tobacco?

☐ No ☐ If yes

Cigarettes per day?

How many years in total have you smoked?

Do you currently or have you ever consumed or used any other substance?

☐ No ☐ If yes

What substance?

For how many years?

Do you currently or have you ever smoked cannabis?

☐ No ☐ If yes

How many times per day?

How many years in total have you smoked?

MEDICAL INSURANCE

Do you have Blue Cross medical insurance?	
Do you have any additional medical insurance?	

SLEEP APNEA QUESTIONS

Question	
Do you snore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?	☐ No ☐ If yes
Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep during driving or talking to someone)?	☐ No ☐ If yes
Has anyone observed you stop breathing or choking/gasping during your sleep ?	☐ No ☐ If yes
Do you have or are you being treated for high blood pressure ?	☐ No ☐ If yes
Is your shirt collar 16 inches / 40cm or larger?	☐ No ☐ If yes

HYPERTENSION QUESTIONS

If you are being treated for blood pressure, are you on more than 3 medications?	

PATIENT'S SIGNATURE

DATE