

# Foothills Family Medical Centre

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Dr. Matthew Schuck  
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To enhance your care we require the following information to confirm your health history.

Our Practice is proud to be a teaching practice for the University of Calgary. We are also pleased to have other team members in our organization to assist in your care.

## HEALTH HISTORY QUESTIONNAIRE

**Patient Name:** \_\_\_\_\_

**Which pharmacy do you deal?** \_\_\_\_\_

**Full Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **Street Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Phone Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Cell Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Work Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Health Care Number** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Emergency Contact Phone #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_