CLINIQUE SANTÉ 360°

Summary
Periodic medical examination

DOSSIER # _____

PATIENT IDENTITY			
Last name :			**Date of birth:**
First name:			Sex : ☐ Men ☐ Women ☐ Other
Quebec health insurance board (RAMQ) :			Expiration date :
Cell phone :	Home :		Work :
E-mail :			
Address :			Flat :
City :			Zip code :
Height:	Weight : ☐ kg ☐ lbs		Nationality :
Profession :			☐ Retired ☐ Student

LEGAL REPRESENTANT FOR PATIENT UNDER 14 YEARS OLD			
First and last name :			Cell phone :
E-mail :			
Relationship :	☐ Mother ☐ Father ☐ Familly member ☐ Legal guardian ☐ Other :		
Are the parents separated? ☐ YES / ☐ NO	If yes, the patient lives with:		

HOW DID YOU HEAR ABOUT OUR CLINIC ?			
☐ Relatives	☐ Facebook	☐ Web search	☐ Local advertising
☐ Other healthcare professionnal	☐ Instagram	☐ Website as Clic-Santé	☐ Radio / newspaper / TV
Referred by :	Do you consent to receive our newsletter by email ? ☐ YES / ☐ NO		

PATIENT'S HEALTHCARE PROFESSIONALS			
Doctor :		Fax :	
Hospital/Clinic :		Phone :	
Pharmacy :		**Fax :**	
Pharmacy address :		Phone :	

CONFIDENTIAL MEDICAL INFORMATION	
To help us make a better assessment of your condition, please fill out this form on your state of heath to the best of your knowledge.	
Allergies / Intolerances and reactions caused:	
Medications taken daily (including contraceptive pill) :	
Date of last health check (with blood tests) and results :	

MEDICAL HISTORY			
IMMUNISATION			
Up-to-date vaccines (Hepatitis, Tetanus, Shingles, etc.)		Covid vaccine (Type, how many doses):	
Significant side effect:		Significant side effect:	
SEXUAL HEALTH			
Have you been sexually active:	In the last 3 months : ☐ YES / ☐ NO		In the last year : ☐ YES / ☐ NO
Year of your last STBI screening:		Results :	
FEMALE HEALTH			
Are you pregnant ? ☐ YES / ☐ NO	Are you breastfeeding? ☐ YES / ☐ NO		For how many weeks :
Are you premenopausal or menopausal? ☐ YES / ☐ NO			Age :
What method of contraception are you using:			Since when :
Results of the last smear test (gynecological exam):			Year :
Results of the last mammography :			Year :
PERSONAL MEDICAL HISTORY			
Describe your active or resolved health problems (diseases, physical/mental state):			
SURGICAL HISTORY			
Describe type/year:			
FAMILY MEDICAL HISTORY			
Father, mother, brothers/sisters, maternal/paternal grandparents. Describe if healthy, if any problem and if dead please add the cause :			

QUESTION AND REASON FOR THE APPOINTMENT

LIFESTYLE HABITS					
CONSOMMATION					
Tobacco :	☐ YES / ☐ NO / ☐ BEFORE	Quantity per day/week:			
Vaping :	☐ YES / ☐ NO / ☐ BEFORE	Quantity per day/week:			
Alcool :	☐ YES / ☐ NO / ☐ BEFORE	Quantity per day/week:	Type :		
Drug :	☐ YES / ☐ NO / ☐ BEFORE	Quantity per day/week:	Type :		
Coffee :	☐ YES / ☐ NO / ☐ BEFORE	Quantity per day/week:			
SOCIAL LIFE					
☐ Single	☐ Spouse(s)	Number of kids :	Support from relatives ☐ YES / ☐ NO		
☐ Student	☐ Employed	☐ Job seeker	☐ Retired	☐ Welfare	
Driver license :	☐ YES / ☐ NO	Classe(s) :			
PHYSICAL FITNESS AND DIET					
Physical activity:	☐ Obesity	☐ Physical inactivity	☐ Physical work	☐ Regular exercise	☐ Intensive exercise
Do you consider your diet to be:		☐ Healthy/balanced	☐ High in fat	☐ High in salt	☐ High in sugar
Number of restaurant meals per week or month:					
Do you follow a specific diet, and if so, which one? (e.g., vegetarian, keto, etc.):					

SYSTEMS REVIEW	
Check those that apply to your condition and add details	
PSY	
☐ Good mood	
☐ Bad mood	
☐ Severe fatigue	
☐ Loss of pleasure/lack of joy	
☐ Stress	
☐ Work/home conflict	
☐ Major event/change	
☐ Psychiatric history	
☐ Psychiatric medications	
☐ Panic attack	
☐ Self-harm	
☐ Other	
SLEEP	
☐ Good sleep	
☐ Lack of/Interrupted sleep	
☐ Insomnia/Sleep apnea	
☐ Other	
APPETTIE AND WEIGHT	
☐ Loss of appetite	

☐ Weight loss	
☐ Weight gain	
☐ Eating disorders	
☐ Other	
NEURO	
☐ Headaches / Migraines	
☐ Numbness / Tingling	
☐ Dizziness / Vertigo	
☐ Weakness	
☐ Loss of vision	
☐ Hearing loss	
☐ Other	
CARDIO	
☐ Palpitation	
☐ Chest Pain (CP)	
☐ Pacemaker	
☐ Other	
PULMONARY	
☐ Difficulty breathing (shortness of breath)	
☐ Asthma	
☐ Cough (wet/dry)	
☐ Expectoration (yellowish/greenish secretions)	
☐ Other	
INTESTINES	
☐ Formed stools	
☐ Diarrhea	
☐ Constipation	
☐ Blood in stool / black stool	
☐ Heartburn / Acid reflux	
☐ Nausea / Vomiting	
☐ Other	
URINARY	
☐ Normal / Color (dark/light)	
☐ Blood in urine	
☐ Difficulty urinating	
☐ Nighttime urination (number of times/night)	
☐ Incontinence or leakage	
☐ Frequent urinary tract infections	
☐ Other	
EYES	

☐ Last check-up with optometrist	
☐ Glasses	
☐ Contact lenses	
☐ Eye surgery	
☐ Other	
LEGS	
☐ Edema (swelling)	
☐ Difficulty walking	
☐ Calf cramps	
☐ Heavy legs	
☐ Other	
MSK	
☐ Joint pain	
☐ Arthritis	
☐ Osteoarthritis	
☐ Osteoporosis	
☐ Scoliosis/Lordosis/Kyphosis	
☐ Fibromyalgia/Chronic Pain Syndromes	
☐ Muscle problems (sprain)	
☐ Other	

As ☐ Patient ☐ Father/Mother ☐ Family member ☐ Guardian , I, the undersigned, _____

certify that the information noted in this document is accurate and/or filled to the best of my knowledge.

CONSENT

By signing this document, you acknowledge that you have understood and accepted our general terms of use and our privacy policy, available on our website and at the reception of our clinics.

General terms of use: www.cliniquesante360.com/conditions-et-modalites

Privacy policy: www.cliniquesante360.com/politique-de-confidentialite

You also consent to the following points:

1. You authorize Clinic Santé 360 and its medical partners to collect, store, modify, or update information deemed necessary for the patient's health monitoring.
2. You consent to the exchange of any medical information between the nurse, pharmacist, and the doctor or any other healthcare professional involved in the patient's health monitoring.
3. You authorize the taking of images or videos of the patient, in whole or in part, to be transferred to their medical record and shared with the medical staff responsible for their monitoring as needed.
4. You understand that the transmission of patient information (record, notes, results, etc.) to a third party not working in collaboration with Clinic Santé 360 (treating physician, insurance company, etc.) will be subject to a different consent form and possibly fees.
5. You understand that in accordance with applicable laws, you may access the patient's information and request corrections or deletions as needed by submitting a written request.

Signature : _____ Date : _____