

Patient Questionnaire

Canada Drug of Topeka, LLC

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How did you hear about Canada Drug?

Television Radio Newspaper

Friend or Relative Billboard

Internet Bench Driving by

Other _____

Dr. _____

Contact Information (please print clearly)

First Name _____

Last Name _____ >CDT

Address _____

City _____

State _____

Zip _____

Email _____

Phone (home) _____

Phone (cell) _____

Phone (work) _____

Employer _____

Primary Physician Name _____

Physician's phone _____

Additional Information

Age _____

Height _____

Weight _____

Date of Birth _____

Gender M F

Regular Exercise? Y N

Do you smoke cigarettes? Y N

Do you drink alcohol? Y N

If yes to any of the 3 above please indicate what type, frequency and duration etc.



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Important please note:

It is mandatory to have had a physical examination within the last 12 months.

Have you had one? Y N

Patient Family History

- 1) Diabetes, thyroid or other endocrine disorder Y N
- 2) Breast cancer Y N
- 3) Hypertension (high blood pressure) Y N
- 4) Cardiovascular (heart or artery disease) Y N
- 5) Lipid (cholesterol) disorder Y N
- 6) Prostate Cancer Y N
- 7) Other forms of cancer Y N
- 8) Migraine Headaches Y N
- 9) Other illness not previously noted Y N

Patient Medical History

- 1) Blood disorders Y N
 - 2) Cancer Y N
 - 3) Immune disorders Y N
 - 4) Poor wound healing Y N
 - 5) Edema or excessive fluid retention Y N
 - 6) Neurological disorders:
(stroke, Parkinson's, Alzheimer's, etc.) Y N
 - 7) Thyroid, diabetes or other endocrine disorder,
including insulin resistance Y N
 - 8) Any known nutrition deficiency including
minerals and electrolytes Y N
 - 9) Hyperlipidemia (high cholesterol) Y N
 - 10) Upper respiratory disorders Y N
 - 11) Lung disorder (i.e., asthma, emphysema) Y N
 - 12) High blood pressure Y N
 - 13) Heart disease including arteriosclerosis, angina
heart failure or history of heart attack Y N
 - 14) Renal or kidney disease Y N
 - 15) Liver disease Y N
 - 16) Drug allergies Y N
 - 17) Orthopedic or muscle disorder, including fracture,
joint disorder or carpal tunnel syndrome Y N
 - 18) Emotional Y N
 - 19) Surgery Y N
 - 20) Glaucoma Y N
 - 21) Rheumatoid arthritis, lupus, or connective tissue
diseases (stomach, ulcers, pancreatitis, etc.) Y N
 - 22) Any medications used in the last 12 months? Y N
- If yes, please specify below:
- _____
- _____
- _____

If you answered yes to any of the Patient Medical History questions, please elaborate in the space below (i.e., duration of illness, any treatment or surgery received, amount smoked and for how long).

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CDT shall not be responsible for any causes of action with respect to any late delivery of medications to me. I understand that pharmaceutical products are non-refundable. I understand that it is my responsibility to have my medical condition and medications obtained from CDT monitored by my American doctor.

By signing this waiver I agree to release liability and hold blameless CDT including their officers and employees, from all causes of action which may arise relating to prescribing or dispensing of my prescription medications.

Print please

Name _____ >CDT

Signature _____

Date _____