New Patient

Name: ____ **Date of Birth**: ________________________________

Female O Male O **Marital Status**: Single O Married O Divorced O Other O Same Sex Partner O

Phone #: ________________ **Cell Phone #**_________________ **Email**: ________________________________

Health Card #: ______________________ **Version Code**: _____ **Expiry Date**: ____________________________

Street Address: ________________________________ **City**: ___________________ **Postal Code**: _________

Occupation: _______________________________________ **Work Phone #** ___________________________

Emergency Contact: ____ Phone # _________________________

Relationship to Patient: _____________________________________

DO YOU CURRENTLY HAVE A FAMILY PHYSICIAN? YES O NO O IF YES, WHO & WHY ARE YOU LEAVING?

____

____

Medical History

O None

Date of Last Physical Examination: __________________________

O High Cholesterol/Fat
O High Blood Pressure
O High Blood Sugar (Diabetes)
O Heart Disease (Heart Attack, Arrhythmia)
O Thyroid Disease
O Depression/Anxiety
O Cancer
  O Bowel/Colon
  O Breast
  O Other ____________________
O Asthma
O Stroke
O Seizures
O Arthritis
O Mental Illness (Bipolar, Schizophrenia, etc.)
O Other
O Osteoporosis

Allergies:

____

____

Medications

O None

Name: _______________________ Dose: _________ | Name: _________________________ Dose: _________

Name: _______________________ Dose: _________ | Name: _________________________ Dose: _________

Name: _______________________ Dose: _________ | Name: _________________________ Dose: _________

Name: _______________________ Dose: _________ | Name: _________________________ Dose: _________

Name: _______________________ Dose: _________ | Name: _________________________ Dose: _________

Name:____

HABITS

Do you smoke? Yes O No O

How many cigarettes/day? ___________

For how many years? ___________

If you've quit, when? ___________ & how long did you smoke? ___________

Alcohol Consumption? Yes O No O If yes, how many drinks/week? ___________

Recreational drug use? Yes O No O If yes, which drugs & how often? ______________________________

WOMEN ONLY

Of pregnancies _______ # of miscarriages/abortions _______ # of living children _______

Date of last Pap test __________________ Any previous abnormal results? Yes O No O

Date of last mammogram __________________ Any previous abnormal results? Yes O No O

Hospitalizations & Surgeries (tonsils, appendix, etc.)

____ Date: ______________________________

____ Date: ______________________________

____ Date: ______________________________

____ Date: ______________________________

____ Date: ______________________________

FAMILY HISTORY

O High Blood Pressure Who: ______________________________ Age: _________

O Heart attack/heart disease Who: ______________________________ Age: _________

O Diabetes (High Blood Sugar) Who: ______________________________ Age: _________

O Cancer O Colon/Bowel Who: ______________________________ Age: _________

O Breast Cancer Who: ______________________________ Age: _________

O other Cancers What kind?_____________________ Who: ____________

O Stroke Who: ______________________________ Age: _________

O Asthma Who: ______________________________ Age: _________

O High Cholesterol Who: ______________________________ Age: _________

O Mental Illness What kind? _____________________ Who: ____________