NEW PATIENT INTAKE FORM

FIRST NAME: _____ PREVIOUS FAMILY PHYSICIAN: _____
LAST NAME: _____ DOB: _____ HEALTH CARD: _____
CONTACT TEL: _____ E-MAIL: _____
ADDRESS: _____
CITY: _____ POSTAL CODE: _____ COUNTRY: _____

EMERGENCY CONTACT INFO:
Relation _____
Relation _____

Is it OK to contact you by e-mail? Yes No
Contact number: _____
Contact number: _____

PAST MEDICAL HISTORY:

_____
_____
_____
_____

PAST SURGERIES AND PROCEDURES:
(please include dates)

_____
_____
_____

FAMILY HISTORY: please indicate any significant medical issues among family members and who they affect
(e.g. Diabetes, Cancer, High blood pressure, heart attack, stroke, lung disease, etc)

_____
_____

PREVENTATIVE HEALTH/LIFESTYLE:
(please circle one)
Do you smoke? Yes No
Do you use any recreational drugs? Yes No
Do you exercise regularly? Yes No
If yes, describe: _____

Do you drink alcohol? Socially / Regular / Never
Family dependents: _____

EDUCATION/OCCUPATION: _____
HOBBIES/INTERESTS: _____
RELIGION/FAITH: _____

PRESCRIPTION MEDICATIONS:

_____
_____
_____
_____

NON-PRESCRIPTION MEDICINES:
(Over- the-counter, herbal, vitamins, other etc)

_____
_____
_____

ALLERGIES:
_____ Reaction: _____ _____ Reaction: _____
_____ Reaction: _____ _____ Reaction: _____

When did you last have the following;

- Pap Smear _____
- Mammogram _____
- Hemoccult- FIT _____
  (stool test for colon cancer screen)
- Colonoscopy _____
- Prostate Exam _____
- Complete Physical _____

- Flu Shot _____
- Pneumonia _____
- Tetanus _____
- HPV _____
- Shingles _____
- Hepatitis A _____
- Hepatitis B _____
- Other _____