Patient Intake Form

Name: (as it appears on health card) _____

Address: _____ **Date of birth**: _____

_____ (mm/dd/yy)

_____ **Postal Code:** _____ **Home Phone**: _____

Health card #: _____ **Work #**: _____

E-Mail: _____ **Mobile #**: _____

Are you looking for a new family doctor & why? _____

_____

Current Family Doctor: _____

(name,address,phone#) _____

How often do you visit your doctor (visits per year?) _____

How did you hear about this office? _____

Please complete the following medical questionnaire. The doctor will review this information with you as part of your first visit.

Marital status: _____ **Occupation**: _____

Do you smoke and how much (packs per day)? _____

Current/past medical problems (eg. Diabetes, kidney problems, high blood pressure):

_____

_____

Previous surgeries/hospitalizations: _____

_____

Medications/Herbals/Vitamins (include doses): _____

_____

_____

Allergies to medications (include any reaction that occurred): _____

_____

Specialists/Consultants that you see regularly: _____

Family History (parents, siblings): _____

_____

Signature:_____ **Date**: _____