A1 MEDICAL CLINIC – PATIENT INTAKE FORM

Dear valued patient,

Please be advised the following information will be kept confidential and will be used by health professionals at A1 Medical for the purpose of managing your health concerns. Any disclosure of your information is conditional to the consent of you or your agent. In case that disclosure of information is obligated by law, the patient and/or patient's agent will be informed.

If you cannot remember an answer or do not feel comfortable with a question, please feel free to leave that field blank.

DEMOGRAPHICS

Patient name:

Date of birth:	Health card number:
Mailing address:	Home phone number:
City:	Work phone number:
Postal code:	Cell phone number:
Emergency contact (Name/Relationship):	Contact number(s):
Regular/family doctor:	

SOCIAL HISTORY

Status:	☐ Single ☐ Engaged ☐ Married	☐ Common law ☐ Widowed ☐ Divorced	☐ Separated
Occupation:			

ALLERGIES

Do you have any allergies?

☐ Yes ☐ No ☐ None known

Allergy:	Reaction:	Severity:

ACTIVITY/EXERCISE

Do you exercise on a regular basis?	☐ Yes ☐ No
If yes, how many minutes per day?	mins/day
How many days of the week do you exercise?	days/week
What type of exercise?	

Please drop off the filled form at the clinic.
Emails & faxes are not acceptable

TOBACCO USE

You are a(n)…

☐ **Non-smoker**	
☐ **Ex-smoker (greater than 5 years)**	Quit date: # of cigarettes smoked/day: # of years of smoking:
☐ **Ex-smoker (less than 5 years)**	Quit date: # of cigarettes smoked/day: # of years of smoking:
☐ **Smoker**	# of cigarettes smoked/day: # of years of smoking:
Other tobacco products used:	

ALCOHOL USE

You have used alcohol…

☐ **Never**	
☐ **In the past**	Quit date:
☐ **Current**	# of days you use/week: # of drinks you consume/day: # of years you have used alcohol: Type of alcohol used:

STREET DRUG USE

You have used street drugs…

☐ **Never**	
☐ **In the past**	Quit date:
☐ **Current**	Type (non-injectable): Type (injectable): # of days you use/week: Amount used /day: # of years you have used street drugs:

MEDICATIONS/SUPPLEMENTS

Are you currently on any medications or supplements?

☐ Yes ☐ No

Medication/supplement name:	Dose:

PAST MEDICAL HISTORY

Please check off the following common chronic conditions that apply to you.

☐ Hypertension (high blood pressure)	☐ Mental health
☐ Diabetes mellitus	☐ Obesity
☐ COPD (chronic obstructive pulmonary disease)	☐ Addiction
☐ Asthma	☐ Tobacco
☐ Heart failure	
☐ Ischemic heart disease	
☐ Chronic renal failure	

Please check off any of the following conditions that apply to you:

☐ Abnormal pap smear
☐ Acne
☐ ADD/ ADHD
☐ Alcohol abuse
☐ Anemia
☐ Anxiety disorder
☐ Bipolar disorder
☐ Bleeding problem
☐ Blood clot
☐ Blood transfusion
☐ Cancer (specify:____________________)
☐ Crohn's disease
☐ Colon polyps
☐ Depression
☐ Diverticulitis
☐ Drug abuse
☐ Eating disorder
☐ Eczema
☐ Frequent urinary tract infections
☐ Frequent sinus infections
☐ Gall stones
☐ Heart attack
☐ Heart condition (specify:_________________)

☐ Hepatitis (type A, B or C)
☐ High cholesterol
☐ Kidney disease
☐ Kidney stone
☐ Lupus
☐ Melanoma
☐ Migraine
☐ Osteoarthritis
☐ Osteoporosis
☐ Positive TB skin test
☐ Prostate problems (specify: ______________)
☐ Psoriasis
☐ Reflux (heartburn)
☐ Rheumatoid arthritis
☐ Rosacea
☐ Seizures
☐ Sexually transmitted infections (specify:_________________)
☐ Stomach ulcer
☐ Stroke
☐ Tuberculosis
☐ Thyroid disease (specify:_________________)

Are there any other conditions you have?

☐ Yes ☐ No

Other conditions:

SURGICAL HISTORY

Have you had any surgeries in the past?

☐ Yes ☐ No

Surgery:	Year:	Surgery:	Year:

FAMILY HISTORY

Please check off any of the following conditions that have occurred in your family and record that relative's relationship to you (eg. father, aunt, daughter) beside the condition.

CARDIOVASCULAR

☐ Cardiovascular disease:..

☐ Heart attack:..

☐ Angina:..

☐ Bypass surgery:..

CANCER

☐ Bowel cancer:..

☐ Breast cancer:..

☐ Melanoma:..

☐ Ovarian cancer:..

☐ Prostate cancer:..

☐ Other cancer:..
(please specify)

MISCELLANEOUS

☐ Addiction:..

☐ Asthma:..

☐ Depression:..

☐ Diabetes:..

☐ High blood pressure:..

☐ High cholesterol:..

☐ Stroke:..

☐ Other mental illness:..
(please specify)

OTHER

Please list any other conditions you think may run in your family and the relative(s) affected:

OBSTETRIC HISTORY

Please fill out the following if it applies.

Are you currently pregnant? ☐ Yes ☐ No

How many pregnancies have you had in the past?

How many live births have you had in the past?