MAPLETON
HEALTH CENTRE

11 Andrews Dr. W
Drayton, ON N0G 1P0
P: (519)638-3088
F: (519)638-3982
E: admin@mapletonhc.ca

New Patient Intake Form

*Please **bring a completed paper copy** of this form to your first appointment for review by your provider. This form is designed to streamline your appointment and to reduce the likelihood that important issues are overlooked. We ask for paper because we find it the better way for your provider to make notes and review with you in person.*

Legal Full Name: _____

Name You Go By: _____

Pronoun *(how you want others to refer to you, such as she, he, they, etc.):* _____

Please tell us your gender identity, if you are comfortable disclosing *(e.g. female, non-binary, male, trans, genderqueer, etc.):*

Sex assigned at birth *(circle one):*

Female Male Intersex Do not wish to disclose

Please tell us your sexual orientation, if you are comfortable disclosing *(e.g. lesbian, bisexual, heterosexual, gay, etc.):*

Current/ongoing medical conditions (*e.g. high blood pressure, high cholesterol, irritable bowel syndrome, depression, etc.):*

Previous/resolved medical conditions *(e.g. childhood asthma, eczema, broken wrist, etc.)*:

Surgeries/procedures or hospitalizations *(please include the year and details of any time you had surgery, or were admitted to the hospital overnight)*:

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Prescription Medications *(include name of medication, dose/strength, and how often you take it, e.g. Lipitor 10 mg once per day, Ramipril 5 mg two times per day, etc.)*:

Over the Counter and Herbal Products:

Allergies *(include the trigger and the reaction you get, e.g. penicillin – rash, peanuts – hives):*

Tobacco History:
☐ Current Tobacco User – How much per day _____
☐ Previous Tobacco User – How long ago did you quit _____
How Do/Did You Consume Tobacco ☐ Cigarettes ☐Vape ☐Other_____
☐ Never Used Tobacco

Marijuana/Drug History:
☐ Currently use Marijuana ☐ Previously used Marijuana
How often: _____ How much per day/week: _____
In what form do/did you consume Marijuana *(e.g. smoking, edibles, tinctures, capsules, etc)*:
_____
☐ Have never used Marijuana

☐ Currently use other drugs/substances *(please list):* _____
☐ Previously used other drugs/substances *(please list)*:_____
☐ Have never used other drugs/substances

Alcohol History: Number of drinks/week: _____

Name and Contact Information of Specialists Involved in Your Care:

Family Medical History *(please indicate family member and age at diagnosis):*

Heart disease, heart attack: ☐No ☐Yes
Family Member and Age at Diagnosis: _____

Stroke: ☐No ☐Yes
Family Member and Age at Diagnosis: _____

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High Blood Pressure: ☐No ☐Yes
Family Member and Age at Diagnosis: _____

Diabetes: ☐No ☐Yes
Family Member and Age at Diagnosis: _____

Thyroid Disorder: ☐No ☐Yes
Family Member and Age at Diagnosis: _____

Breast, Ovarian, Colon or Prostate Cancer: ☐No ☐Yes
Family Member and Age at Diagnosis: _____

Mental Illness *(e.g. anxiety, depression, bipolar, schizophrenia, etc):* ☐No ☐Yes
Family Member and Age at Diagnosis: _____

Other: _____

Children *(please list names, gender, year of birth & any serious illness):*

Relationship Status, if you are comfortable disclosing: _____

Current Occupation, if you are comfortable disclosing: _____

Country of Birth, if you are comfortable disclosing: _____

Previous Family Doctor's Contact Information:

Pharmacy Contact Information:

*Finally, please bring all your **medications** and **immunization records** to your first appointment.*