

## **EAGLE CREEK MEDICAL CLINIC**

**#120 – 27 Helmcken Road, Victoria, BC, V8Z 2C5**

**<https://eaglecreekmedicalclinic.ca/>**

### **Welcome to Eagle Creek Medical Clinic. You have either been assigned to join the Primary Care Practice of one of our Family Physicians or Nurse Practitioners.**

*What is a Nurse Practitioner?* A Nurse Practitioner (NP) is an advanced practice nurse (RN) who completed a graduate level degree in order to provide primary care services which include assessing your health concerns, diagnosing conditions, ordering diagnostic studies, writing prescriptions, referring to specialists and more.

After completion of the Meet and Greet appointment – if both you and the Doctor/NP confirm a mutual fit – the Doctor/NP will commence care as your primary care provider and discuss the next steps regarding your health care. It will ultimately be up to you to ensure you attend appointments and follow up after diagnostic tests and bloodwork are completed.

We are currently offering both telehealth (telephone, video) and in-person appointments in the setting of COVID-19. It is important to note there are limitations to telehealth appointments if we are not able to see you, conduct an assessment or check your vital signs etc. and we may ask you to come in for an in-person exam. We suggest using your own phone or computer for telehealth and to be in a private space where no one can overhear the conversation in order to maximize confidentiality. We ask that you do not take a phone call while driving.

We ask that you limit health concerns to 1-2 per appointment so that we have lots of time to address your concern and come up with a plan of care together. It is important to us that you are informed about your health care and that we are respectful of your time and other patient's time.

Please note, there may also be a No-Show fee if you do not show up for booked appointments. Failure to show up 2 times without warning may also result in removal from the Doctor/NP list as there are currently a large wait list of patients waiting to find a primary care provider. Verbal threats or acts of violence will not be tolerated.

**We are unable to accept care for you if you already have a family doctor/NP elsewhere.**

Thank you,  
The Primary Care Network team at Eagle Creek Medical Clinic

PATIENT INTAKE FORM

Drop off at Eagle Creek Medical Clinic between 8:30-4:30 Monday – Friday Patient

Name:	Phone:
Address:	
Date of Birth	PHN:
Email Address:	
Emergency Contact & Relationship:	

1. **Past Medical History:** (ex. high blood pressure, diabetes, thyroid condition, asthma, cancer, depression, anxiety, COPD, heartburn, high cholesterol etc.)

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Surgeries and/or hospitalizations (please include **dates**):

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Are any specialists involved in your care? \_\_\_\_\_

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2. **Allergies (food, environment, medications):** Please indicate reaction.

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3. **Medications (prescription, over-the-counter, supplements, herbs):** Please indicate **dose, frequency, and how long you have been taking it.**

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Which pharmacy do you use? (Name, location) \_\_\_\_\_

4. **Family history:** Please indicate any medical conditions in your family members, if indicated:

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings \_\_\_\_\_

Maternal Grandmother \_\_\_\_\_

Maternal Grandfather \_\_\_\_\_

Paternal Grandmother \_\_\_\_\_

Paternal Grandfather \_\_\_\_\_

Aunts & Uncles \_\_\_\_\_

**5. Social:**

- How do you spend your days? (work – what do you do?, school, retired) \_\_\_\_\_
- Do you identify as male/female/non-binary? \_\_\_\_\_
- Who do you live with? \_\_\_\_\_
- Do you exercise? **Yes/No** What / how often \_\_\_\_\_
- Do you follow a certain diet? (vegan, vegetarian, keto, etc) \_\_\_\_\_
- Do you drink alcohol? **Yes/No** How many drinks per day/week/month? \_\_\_\_\_
- Do you smoke cigarettes/tobacco products/e-cigarettes? **Yes/No**  
If yes, how many packs per day? \_\_\_\_\_  
Did you previously smoke? How much? When did you quit? \_\_\_\_\_
- Do you use cannabis or any other drugs? **Yes/No** How much / how often? \_\_\_\_\_
- How would you rate your overall stress level on a scale of 0 to 5?  
No stress    0  1  2  3  4  5  Extremely stressed

**6. Immunizations:** Please indicate approximate **date** of administration

- Did you have childhood immunizations? \_\_\_\_\_
- > 50 years old: Shingles vaccine? \_\_\_\_\_
- > 65 years old: Prevnar 13? \_\_\_\_\_ Pneumovax? \_\_\_\_\_
- When was your last Tetanus vaccine (Td or Tdap)? \_\_\_\_\_
- COVID-19 vaccine: \_\_\_\_\_

**7. Screening:** Please indicated the **date** of your last test

- Last FIT test: \_\_\_\_\_ OR Last Colonoscopy: \_\_\_\_\_
- Blood work (such as diabetes screen, cholesterol, iron studies, etc.) \_\_\_\_\_
- Bone Density Scan (if applicable) \_\_\_\_\_
- Last dentist appointment \_\_\_\_\_
- Last optometrist appointment \_\_\_\_\_
- **If male:** Prostate exam, PSA (blood test): \_\_\_\_\_
- **If female:** Last PAP: \_\_\_\_\_ Last Mammogram: \_\_\_\_\_  
**Number of pregnancies & delivery type:** \_\_\_\_\_  
**Family planning goals:** \_\_\_\_\_  
**Have you reached menopause (what age/year):** \_\_\_\_\_

**8. Do you have any particular goals of health you would like me to be aware of?**

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