Eagle Creek Medical Clinic
#120 – 27 Helmcken Road, Victoria, BC

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PATIENT INTAKE FORM

**for**

**NURSE PRACTITIONERS: Rene Korchinski or Courtney Ellis**

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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* 1. Surgeries

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

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

**[Which pharmacy do you use? (name, location**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

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1. **Family history (parents, siblings, grandparents).** *Which medical conditions run in your family?*

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1. **Social**
	1. How do you spend your days? (work, school, retired) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Do you identify as male/female/non-binary?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	3. Which pronouns do you prefer? (he, him, she, her, they, them, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	4. Who do you live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	5. Do you exercise? **Yes/No**

*If yes, what do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many times a week? \_\_\_\_\_\_\_\_\_\_\_\_\_*

* 1. Do you follow a certain diet? (vegan, vegetarian, keto, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Do you drink alcohol? **Yes/No***If yes, how many drinks per day/week/month? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*
	3. Do you smoke cigarettes/tobacco products/e-cigarettes? **Yes/No**

*If yes, how many per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

* 1. Do you use cannabis or any other drugs? **Yes/No**
	*If yes, how frequently?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*
	2. 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**

1. **Are your immunizations up to date? Yes/No/Unsure**
2. **Screening (if applicable):**

*If known, when was your last of the following tests:*

FIT/Colonoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood work (such as diabetes screen, cholesterol, iron studies, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If male:**

Prostate exam, PSA (blood test) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If female:**
Last Pap smear:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Mammogram:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Menstrual Period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is your cycle regular?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Number of pregnancies/type of deliveries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Current family planning goals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you reached menopause? **Yes/No***. If yes, at what age?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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

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1. **Emergency Contact Information**
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_