TAMARACK
Medical Group

Suite 191, 1500 Cranbrook St N
Cranbrook, BC  V1C 3S8
www.tamarackmedicalgroup.com
**Tel.  250 426 7724**
**Fax. 250 426 0671**

Welcome to the Tamarack Medical Group!

We are happy you have trusted us with your health, and our team is ready to work with you and your health needs.  Our goal is to ensure a safe environment, focus on preventative care and a patient focused approach.

By coming into the practice we ask from you to:

• Seek health care from your practitioner and/or team whenever possible.  Name your practitioner as your primary care provider when you visit an emergency facility or another provider.

• Communicate with your practitioner honestly and openly to help best address your healthcare needs.

- One issue per visit.

Please complete the attached intake form, email consent form, and release of records form (please advise us if there are more than one place to retrieve your records).  Return the forms either by email or drop them off to the front desk at the clinic.

Once your practitioner has reviewed your forms and received your records, you will be contacted to book an appointment in the office.

If you have any questions or concerns please feel free to contact us at 250 426 7724.

We look forward to meeting with you in the near future and sharing in your health care journey.

Sincerely,
Tamarack Medical Group

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office@tamarackmedicalgroup.com
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Please complete to the best of your ability and email back to office@tamarackmedicalgroup.com or drop off at the clinic

## PERSONAL INFORMATION:

FULL NAME: _____

PREFERRED NAME: _____

DATE OF BIRTH (DD/MM/YYYY): _____ PHN (Health care number): _____

SEX AT BIRTH: _____ GENDER: _____ PREFERRED PRONOUNS: _____

Address: _____

City: _____

Postal Code: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Preferred number to call: H / C / W

Emergency Contact Name: _____ Phone: _____

EMAIL: _____

Current Height: _____ (cm ) Current weight: _____ (kgs)

## PHARMACY INFORMATION:

You have my permission to request my prescription medication history for treatment purposes.

My preferred pharmacy:

Name: _____

Address: _____

** Please inform the clinic if your preferred pharmacy information changes. Thank you.

| **ALLERGIES:** Include medication / environmental / food | |
|---|---|
| **Allergy** | **Description** |
| | |
| | |
| | |
| | |
| | |
| **DRUG INTOLERANCES:** | |
| | |
| | |
| | |
| | |

| **MEDICATION** | **DOSE** | **HOW OFTEN** |
|---|---|---|
| | | |
| | | |
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|---|---|---|
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| HISTORY OF SURGERY OR OTHER PROCEDURES: | | |
|---|---|---|
| **Date of Surgery / Procedure** | **Type of Surgery / Procedure** | **Hospital or Clinic where performed** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you have an Internal Electronic Device (example: defibrillator, pacemaker, etc) ? Y / N

| HISTORY OF RADIATION OR CHEMOTHERAPY: | | |
|---|---|---|
| **Date:** | **Type of treatment:** | **Location:** |
| | | |
| | | |
| | | |
| | | |
| | | |

| PAST OR CURRENT CONDITIONS (Example: hypertension, diabetes, high cholesterol, arthritis, etc) | |
|---|---|
| 1. | 7. |
| 2. | 8. |
| 3. | 9. |
| 4. | 10. |
| 5. | 11. |
| 6. | 12. |

| CURRENT OR PAST FAMILY PRACTITIONER: | |
|---|---|
| **Name:** | **Location/Address:** |
| | |
| | |
| | |
| | |
| | |

| SOCIAL HISTORY: |
|---|
| What is your race / ethnicity? |
| What kind of work did/do you do? |
| Do you have children? Y / N List ages: |
| Do you drink alcohol? Y / N Number of drinks per week: |
| Do you use tobacco products now or in the past? (cigars, cigarettes, tobacco) Y / N<br>Number of years: _____ Number of packs per day: _____ When did you quit? _____<br><br>Are you interested in information regarding smoking cessation? Y / N |
| Do you use recreational drugs? Y / N What drugs? How often: |
| Do you have special religious, spiritual, or cultural needs we need to be aware of? Y / N<br>If yes, please explain: |
| Do you have Advanced Directives (living will, power of attorney for health care)? Y / N<br>If yes, could you provide a copy for your records? Y / N |
| Exercise:<br>Type: Frequency:<br><br>Type: Frequency: |
| Hobbies: |

**FAMILY HISTORY:** Please list any cancer or disease your family members have had. If you do not know the exact ages please estimate.

| FAMILY MEMBER | CURRENT AGE | AGE OF DIAGNOSIS | AGE AT DEATH | TYPE OF CANCER / DISEASE |
|---|---|---|---|---|
| Yourself | | | | |
| ***Your Siblings (please circle either sister or brother)*** | | | | |
| Sister Brother | | | | |
| Sister Brother | | | | |
| Sister Brother | | | | |
| Sister Brother | | | | |
| Sister Brother | | | | |
| ***Your Children (please circle either daughter or son)*** | | | | |
| Daughter Son | | | | |
| Daughter Son | | | | |
| Daughter Son | | | | |
| Daughter Son | | | | |
| Daughter Son | | | | |
| ***Your Father's Family (please circle either Aunt or Uncle)*** | | | | |
| Father | | | | |
| Paternal Grandfather | | | | |
| Paternal Grandmother | | | | |
| Aunt Uncle | | | | |
| Aunt Uncle | | | | |
| Aunt Uncle | | | | |
| Aunt Uncle | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |
| ***Your Mother's Family (please circle either Aunt or Uncle)*** | | | | |
| Mother | | | | |
| Maternal Grandfather | | | | |
| Maternal Grandmother | | | | |
| Aunt Uncle | | | | |
| Aunt Uncle | | | | |
| Aunt Uncle | | | | |
| Aunt Uncle | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |

## Gynecological / Obstetric History – WOMEN ONLY

Have you gone through menopause? Y / N How old were you?

PREGNANCIES:

| DATE: | OUTCOME: | COMPLICATIONS: | |
|---|---|---|---|
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Abortion (s):

## HEALTH MAINTENANCE

**Men and Women**

Have you had a sigmoidoscopy or colonoscopy? N / Y Date:

Has your doctor checked your stool for blood? N / Y Date:

Have you had an oral or dental exam? N / Y Date:

Have you had a flu vaccination? N / Y Date:

Have you have a COVID vaccination? N / Y Date:

Have you had a pneumonia vaccination? N / Y Date:

Have you had a shingles vaccine? N / Y Date:

**Women Only**

Do you have regular mammograms? N / Y Date:

Do you have regular PAP tests? N / Y Date:

Have you had a bone density test? N / Y Date:

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# EMAIL CONSENT

I,_____ (print name) understand that my practitioner uses reasonable means to protect the privacy and security of electronic communication, and it is not possible to completely secure the information. Electronic communication can be forwarded, intercepted, stored, or even changed without the knowledge or permission of the patient or Practitioner.

I give my consent to have my chart information sent electronically and I realize the risks involved. I will update the clinic with any changes in my information or email address.

Consent given:

_____ _____

(Signature) (Date)

- Please note in addition some of the practitioners use various transcribing services (Tali, Freed, etc) to provide the best care and attention. It transcribes conversations and helps with the practitioners notes. Your information is private and confidential and will be reviewed for accuracy. You can inform your practitioner at anytime if you do not want this transcribing service.