Family Practice Background Form

Date:____________________

Personal History

Last Name:_____________________________

First Name:_____________________________

D.o.B: m:_____d:____y: _____

Gender: Male / Female

Address:_______________________________

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City:__________________________________

Postal Code:____________________________

Primary Phone #:_________________________

Work/Home #:___________________________

Email Address:__________________________

Health Card #:__________________________

Ex date:_________________________

Occupation:_____________________________

Previous Family Doctor:___________________

Previous Family Doctor Phone Number:

____

Emergency Contact

Name:_______________________________

Phone #:_____________________________

Relation:_____________________________

Preventative Care

please provide the most recent date of:

Pap smear (females)	____________
Mammogram (females)	____________
Colonoscopy	____________
Fecal occult blood test	____________
Bone mineral density	____________
Pneumovax	____________
Tetanus vaccine	____________
Herpes Zoster Vaccine	____________

Medical History

	yes	no
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Asthma	☐	☐
High Cholesterol	☐	☐
Surgery (explain below)	☐	☐
Smoker (including Cannabis)	☐	☐

Additional Medical History

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Current Medication

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Allergies

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Please attach a copy of your immunizations record if available.