NEW PATIENT INTAKE FORM

Norfolk Family Medical

DATE: _____

NAME AS IT APPEARS ON HEALTH CARD: _____
SURNAME FIRST MIDDLE

PREFERRED NAME: _____ GENDER: _____ BIRTH SEX: _____

PREFERRED PRONOUN: _____
(IF ANY)

BIRTHDATE: _____

AGE: _____

OCCUPATION: _____

EMPLOYER: _____

MARITAL STATUS: _____

PARTNER/SPOUSE NAME: _____

EMERGENCY CONTACT:

- NAME: _____
- RELATIONSHIP: _____
- PHONE: _____

_____
ADDRESS CITY PROVINCE POSTAL CODE

_____
HOME PHONE WORK PHONE (EXT) CELL PHONE

_____
EMAIL ADDRESS

_____
ONTARIO HEALTH CARD # VERSION CODE EXPIRY DATE

_____
PREVIOUS FAMILY PHYSICIAN (NAME & LOCATION)

_____
SPECIALISTS INVOLVED IN YOUR CARE (NAME & SPECIALTY)

_____
CHILDREN (if applicable) - NAME & AGE

Please see reverse page

PERSONAL MEDICAL HISTORY:
Check any illnesses/conditions YOU have had

- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Kidney disease *specify:* _____
- ❑ Thyroid problems *specify:* _____
- ❑ Lung disease *specify:* _____
- ❑ Blood clot *specify:* _____
- ❑ Tuberculosis
- ❑ Blood disorder *specify:* _____
- ❑ Skin condition *specify:* _____
- ❑ Asthma
- ❑ Heart condition *specify:* _____
- ❑ Arthritis
- ❑ Gastrointestinal issues *specify:* _____
- ❑ Stroke
- ❑ Diabetes
- ❑ Hepatitis A/B/C (circle one)
- ❑ Osteoporosis
- ❑ Cancer *specify:* _____
- ❑ Anxiety/Depression

FAMILY MEDICAL HISTORY:
Check any illness/conditions your immediate FAMILY has had

- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Kidney disease *specify:* _____
- ❑ Thyroid problems *specify:* _____
- ❑ Lung disease *specify:* _____
- ❑ Blood clot *specify:* _____
- ❑ Tuberculosis
- ❑ Blood disorder *specify:* _____
- ❑ Skin condition *specify:* _____
- ❑ Asthma
- ❑ Heart condition *specify:* _____
- ❑ Arthritis
- ❑ Gastrointestinal issues *specify:* _____
- ❑ Stroke
- ❑ Diabetes
- ❑ Hepatitis A/B/C (circle one)
- ❑ Osteoporosis
- ❑ Cancer *specify:* _____
- ❑ Other:_____

OTHER MEDICAL HISTORY:

_____

SURGICAL HISTORY and/or SURGICAL COMPLICATIONS:

_____

Tobacco use:
[ ] Never
[ ] In the past - quit date: _____
[ ] Presently
- How much? _____
- How long? _____

Alcohol use:
[ ] Yes - avg # of drinks per week
_____
[ ] No

Other drug use (current or past):
[ ] IV drugs
[ ] other: _____

Exercise: _____

Dietary Restrictions: _____

Private Drug Plan: [ ] Yes [ ] No

Preventative Health:
*List the **most recent** year and location of each as applicable*

Tetanus vaccine _____
Flu vaccine _____
Mammogram _____
- ❑ All normal
- ❑ Past abnormal

Pap smear _____
- ❑ All normal
- ❑ Past abnormal

PSA _____
Colon cancer screen
- Colonoscopy _____
- Stool kit _____

Additional VACCINATIONS (e.g. Hepatitis A, typhoid, etc.)
_____
_____

CURRENT MEDICATIONS:
**Including over-the-counter medications and vitamins*
**attach a separate list if needed*
_____
_____
_____
_____
_____
_____

ALLERGIES & REACTION:
_____
_____
_____
_____

Financial: Any trouble making ends meet at the end of the month?
[ ] Yes [ ] No

Please list any active medical concerns you wish to discuss:

_____
_____
_____