NEW PATIENT FORM

Name:

First MI Last

Address:

Street name

City Province Postal code

DOB:

Year Month Day

Phone:

Home Work Cell

Email:

Preferred method of contact:

Emergency contact:

Name Relationship Phone number

Family Physician:

Name Clinic name

Are you taking any medications? If yes, please provide us with a complete list or list them below:

Allergies:

Are you currently being treated or have been treated for any medical conditions within the past year? If yes, please describe below:

Do you have or have ever had any of the following? Check all that apply.

- ☐ Stroke
- ☐ Asthma or emphysema
- ☐ Lung disease
- ☐ Cancer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart murmur
- ☐ Heart valve repair or replacement
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ HIV/AIDS

- ☐ Anxiety
- ☐ Hyper/hypoglycemia
- ☐ Shortness of breath
- ☐ Any other communicable diseases

Are you pregnant or breastfeeding?

What is the purpose of your visit today?

If you have any additional information that you wish to disclose, please do so here:

I declare that all the information I have provided on this form is true and correct:

Signature of patient Date