Bluewater Area Family Health Team

New Patient Health Information Form

Patient Information:

Last name:_____________________ First Name:_________________________
Sex:___________
Health Card Number:_________________ Version Code:______
Date of Birth:______________
Marital Status:__________________ Number of Children:_______
Occupation:_____________
Address/Box #:___________________________ City:____________
Postal Code:_____________
Home Phone #:__________________ Cell #:__________________
Work #:_________________
Preferred Pharmacy:_______________________________________
Email Address:____
Next of Kin/In case of Emergency:
Contact:____
Relationship:________________________________
Phone Number:________________________

Do you have a current Physician? If yes please provide name, location and reason for leaving:

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Medical History:

Do you have/ever had the following:

Please give details eg. When diagnosed, Specialist involved, surgeries involved etc.

Please use back of page if necessary.

Diabetes/Prediabetes/ Gestational Diabetes	Asthma/COPD/Lung Conditions
Previous Heart Attack/Surgery	Angina
Abnormal Heart Rhythm	High/Low Blood Pressure

High Cholesterol	Blood Clots
Swelling in feet/ankles/legs	Congestive Heart Failure
GERD/Stomach/Bowel Issues	Overweight
Arthritis	Back Issues
Osteopenia/Osteoporosis	Thyroid Problems
Hysterectomy	Problems with Kidneys/or Urination
Liver Problems	Cancer (type)
Epilepsy/Seizures	Mental Health Depression/Anxiety
Sexually Transmitted Infection	Previous Surgeries
Other	

Allergies:
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Lifestyle:
Exercise: mins per week:_______________________________
Smoking: YES NO QUIT When:__________ How many per day:__________
How many years:____________
Recreational Drug use eg. Marijuana, Cocaine, etc. YES NO
If yes how much:______________
Alcohol Intake: NEVER 1-5/week 5-10/week Other:________________
Caffeine (coffee/tea): cups per day____________________

Medications:
Please list all medications that you are currently taking, including Opioids and Inhalers:
(or attach a current list from the pharmacy)

Name of Medication	Dosage and Quantity

Please list all Vitamins or Supplements:

Name of Vitamin/Supplement	Dosage and Quantity

Recent/Past Surgeries/Hospitalizations (date if known/approx.):
Name and Date of Surgery:

<u>Immunizations/ Preventative Care </u>(Please attach a copy of children's immunization records):

Last Tetanus shot:_________ Last Flu shot:_________ Last Pneumonia shot:_______
Hepatitis B shot: _________ Zostavax/Shingrix shot:_________
Last Mammogram:______________ Result:________________
Last Colonoscopy/ Colorectal Screening:_______________ Result:_________________
Last Pap test:________________ Result:_______________
Last Bone Mineral Density test:_______________ Where:______________
Covid-19 Vaccine(s) Dates/Type of Vaccine:
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Family History:

If any relative has suffered any of the following, please indicate which relative:
(Mother, Father, Sister, Brother or children only required, not extended family)

Epilepsy	Migraines
Mental Illness	Glaucoma
Diabetes	Thyroid Disease
Hay fever	Asthma
Anemia	Skin Condition
Bleeding Disorder	Arthritis
Osteoporosis	Heart Disease
Stroke	High Blood Pressure
High Cholesterol	Alcoholism
Genetic Disorder	Cancer (and Type)
Other (please specify):	

Additional Comments and or Concerns:

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