Bluewater Area Family Health Team

New Patient Health Information Form

Please fill out all areas on the application form. Failure to do so will result in a delayed response.
Providing false information on this application form may affect your acceptance to Bluewater Area Family Health Team.

Patient Information:

Last name:____________________ First Name:________________________
Birth Gender:_______________ Preferred Pronoun:____________________
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:

____

____

Have you ever been discharged from another physician? If so, what was the reasoning. Please explain.

____

____

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
Substance Abuse/Alcohol/Drugs	Other

Allergies:

____

____

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 any controlled medications and stimulants (ADHD medication).** Please also include Inhalers: (or attach a current list from the pharmacy)

Name of Medication	Reason for this medication	Dosage & Quantity	Length of time taking this medication

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:

____

____

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):	Substance Abuse

I, ______________________________ (name) attest that the information given is accurate and true.

Signature: ____