SOUTHTOWN MEDICAL & WALK-IN CLINIC

2-405 Centre Street
Winnipeg, Manitoba
R3Y 0V8

Phone: 204-306-2217
Fax: 204-306-2218

PREFERRED PHYSICIAN

- ☐ Male Physician
- ☐ Female Physician
- ☐ No preference

NEW PATIENT INTAKE AND MEDICAL HISTORY FORM

Please complete the information below to the best of your knowledge. Should you require assistance, please ask a Medical Office Assistant.

DEMOGRAPHIC

First Name: _____ Last Name: _____

Gender: _____ Weight: _____ kg Height: _____ cm Marital Status: _____

Address: _____ Unit: _____ City: _____

Province: _____Postal code: _____ Home Phone: _____

Cell Phone: _____ Email:_____

Date of Birth *(mm/dd/yyyy)*: _____

Emergency contact Emergency Contact Name: _____

Phone number: _____ Relationship: _____

FEMALE PATIENTS: Last Pap test: _____ Last Mammogram: _____

PAST MEDICAL HISTORY

Condition	Year of diagnosis	Do you see a specialist for this?	Active or Resolved?

PAST SURGICAL HISTORY

(please include wisdom teeth, LEEP, colonoscopy, eye surgery if applicable):

Type of surgery	Year of surgery	Do you see a specialist for this?	Active or Resolved?

PRESCRIPTION MEDICATIONS

Medication name	Dosage	Frequency	Why do you take it?	How long have you been taking it?

ALLERGIES

Medication Allergy: _____Reaction: _____

Medication Allergy: _____Reaction: _____

Non-medication Allergy:_____Reaction: _____

Do you carry an Epi-Pen (circle option)? YES NO

SOCIAL HISTORY

DO YOU USE THE FOLLOWING (circle option)*:*

Narcotics: YES NO Tylenol #3: YES NO Benzodiazepines or Barbiturates: YES NO

If you use any of the following, please indicate and list the frequency of each where applicable:

	YES or NO	Frequency of use	If quit use, please include date
Alcohol			
Recreational Drugs			
Marijuana			
Cigarettes (if yes, how many per day?)			
Other:			

Occupation: _____

FAMILY HISTORY

Please indicate if any direct relatives (parents, grandparents and siblings) have any health conditions such as cancer, diabetes, ailments of: heart, kidney, lungs or other:

Family member	Condition

OTHER

Any other health concerns, conditions or medications:

_____

_____

Patient Signature: _____

Date: _____