

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: _____

Once completed, you can drop off the form to our office or email to info.southtownmed@gmail.com