New Patient Intake Form

Scurfield MEDICAL CENTRE

PATIENT INFORMATION

First Name: _____ Last name: _____ Date of Birth: _____

Sex: F / M / other _____ Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Primary Phone #: _____ Secondary Phone #: _____

MEDICAL INFORMATION

Previous Family Doctor: _____ Previous Clinic: _____

Pharmacy: ☐ Scurfield Pharmacy ☐ other: _____

Medical conditions:

_____

_____

_____

_____

_____

_____

_____

Medications *(include dosages if known):*

_____

_____

_____

_____

_____

_____

_____

Allergies *(include severity/reaction):* _____

Previous Surgeries *(include year):* _____

Specialists involved in your care *(include specialty):* _____

_____

****CONTINUED ON REVERSE PAGE****

FAMILY HISTORY

Has anyone in your family had any of the following conditions? *(Please circle and list relationship to you)*

Heart disease _____ Diabetes _____

High cholesterol _____ High blood pressure _____

Bleeding disorders _____ Stroke/Heart Attack _____

Asthma _____ Kidney disease _____

Mental health concerns _____

Cancer (type) _____

Other _____

SOCIAL HISTORY

Marital status: _____ Occupation: _____

Do you have children? Yes or No # of Children: _____ Ages: _____

What do you do for exercise? _____ How many hours/week? _____

☐ Non-smoker ☐ Current smoker ☐ Former smoker

Packs per day _____ Number of years _____ If you quit, when? _____

Alcohol use: Yes or No If yes, how many drinks per week/month? _____

Cannabis use: Yes or No If yes, how often? _____ Other recreational drug use: _____

CANCER SCREENING HISTORY

Have you had any of the following cancer screening? *(Please circle and list the year last completed, if known)*

Pap test _____ Mammogram _____ FOBT (stool testing) _____ Colonoscopy _____

Any previous abnormal results: Yes or No If yes, what test and when? _____

If you've had a colonoscopy, who performed the procedure? _____ What hospital? _____

Patient/Guardian signature: _____ Date: _____