MEADOWCARE
MEDICAL CLINIC
With You on Your Health Journey Every Step of the Way!

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NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

Desired Family Physician (Circle Choice): Dr. Perveen (Female) Dr. Obiora (Male)

First Name: _____ Last Name: _____
DOB (YYYY/MM/DD): _____ PHIN (9-digit): _____
MHSC (6-digit): _____ Age: _____ Gender: _____
Marital Status: _____ Height: _____ Weight: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Occupation: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____
Relationship to Client: _____ Phone: _____

HEALTH INFORMATION

Allergies (if known): _____
Specific Diet: Vegan Vegetarian Non-Vegan
Current Medications: For What Condition(s):
1. _____ A. _____
2. _____ B. _____
3. _____ C. _____
4. _____ D. _____
5. _____ E. _____
Narcotics: Y / N Tylenol #3: Y / N Benzodiazepines or Barbiturates: Y / N
Last Pap (female only): _____ Last Mammogram (female only):_____
Last TD: _____ Other Immunizations: _____
Past Surgeries (also include date and location):
1. _____
2. _____
3. _____
4. _____
5. _____
Do you use any of the following (list type and frequency, if applicable):
Alcohol: _____ Recreational Drugs: _____
Marijuana: _____ Cigarettes: _____
If yes to Cigarettes, how many per day: _____ If QUIT, what date: _____

FAMILY HISTORY

Has a close relative (parents, grandparents, siblings) been diagnosed with cardiovascular disease, renal disease or diabetes? If yes, please mention condition and age when diagnosed.
1. _____
2. _____
3. _____
4. _____
5. _____

Any additional health concerns you'd like to mention?
_____
_____

Name ***Signature*** ***Date***