

## Adult Health History for NEW Patients of the Practice: (Age >18)

MY INTAKE APPOINTMENT IS WITH DR. \_\_\_\_\_

TO BOOK APPOINTMENTS ONLINE, MY ACCESS CODE IS: \_\_\_\_\_

(email [info@elicare.ca](mailto:info@elicare.ca) or visit clinic reception for access codes).

Please visit [elicare.ca](http://elicare.ca) to book online appointments.

If you are uncomfortable with any question, do not answer it. Thank you! Leave blank if it is not applicable to you.

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (YYYY/MM/DD) Carecard #: \_\_\_\_\_

Telephone (Best): \_\_\_\_\_ Telephone (2ndary): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation to you: \_\_\_\_\_

**CURRENT ISSUES:** Main reason for today's visit: \_\_\_\_\_

Where were you getting your care before?: (doctor/clinic) \_\_\_\_\_

**PSYCH EVALUATION:** In the past 2 weeks, have you been bothered by:

- No  Yes Little interest or pleasure in doing things?  
 No  Yes Feeling down, depressed or hopeless?  
 No  Yes Anxious, keyed up, or on edge?

**PAST MEDICAL HISTORY:** What past medical issues to you have? (For example, diabetes, high blood pressure...) \_\_\_\_\_

What surgeries have you had in the past? (For example, appendix, gall bladder, tonsil surgeries...) \_\_\_\_\_

Surgery	Date

**MEDICATIONS:** What medications do you take?:

Medication Name and Dose (if known)	How do you take it?	Why?

If there are more than can fit on this form, please bring a copy of written Rx's or go to a pharmacist and have them print one out for you.

What allergies do you have?:

### CONDITIONAL/REGULAR CHECKS

Have you had the following tests? If so, when?

● Stool test for blood (FIT) <input type="checkbox"/> No <input type="checkbox"/> Yes, date: _____	● Mammograms <input type="checkbox"/> No <input type="checkbox"/> Yes, date: _____
● Pap smears <input type="checkbox"/> No <input type="checkbox"/> Yes, date: _____	● Colonoscopy <input type="checkbox"/> No <input type="checkbox"/> Yes, date: _____

**FAMILY HISTORY:**

Do you have any FAMILY MEMBER with a history of

● Heart attack <input type="checkbox"/> No <input type="checkbox"/> Yes, who: _____	● Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, who: _____
● Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes, who: _____	● Hip fractures <input type="checkbox"/> No <input type="checkbox"/> Yes, who: _____
● breast cancer <input type="checkbox"/> No <input type="checkbox"/> Yes, who: _____	● colon cancer <input type="checkbox"/> No <input type="checkbox"/> Yes, who: _____
● anxiety <input type="checkbox"/> No <input type="checkbox"/> Yes, who: _____	depression <input type="checkbox"/> No <input type="checkbox"/> Yes, who: _____
● suicide <input type="checkbox"/> No <input type="checkbox"/> Yes, who: _____	● alcohol/substance use <input type="checkbox"/> No <input type="checkbox"/> Yes, who _____

**SUBSTANCE USE HISTORY:** Do you smoke?  No  Yes, \_\_\_\_\_ packs a day for \_\_\_\_\_ years  I quit in \_\_\_\_\_ (year) after smoking for \_\_\_\_\_ years

How many alcoholic beverages do you drink in a week? \_\_\_\_\_

 drinks Do you use recreational substances?  No  Yes

**SOCIAL HISTORY:** Occupation (or prior occupation): \_\_\_\_\_

retired/unemployed/leave of absence/disabled (circle one)

Years of education or highest degree: \_\_\_\_\_ Marital status (circle one): single, partner, married, divorced, widowed, other: \_\_\_\_\_ Spouse/partner's name: \_\_\_\_\_

Number of children: \_\_\_\_\_ Ages if under 18 years: \_\_\_\_\_

Who lives at home with you? : \_\_\_\_\_

Leisure activities, group involvement, religion, volunteer work, recent travel:

**WOMEN'S HEALTH HISTORY:** Total number of pregnancies: \_\_\_\_\_ Number of births: \_\_\_\_\_

Date (month/day if known) of last menstrual period if you are still menstruating: \_\_\_\_\_

Age at beginning of periods (menstruation): \_\_\_\_\_ Age at end of periods (menopause): \_\_\_\_\_

**OTHER INFORMATION:**

Do you have anything else you would like us to know about you?: \_\_\_\_\_

**PharmaNet search:**

- Knowing what medications you have been prescribed is very important for proper medical care
- You consent to the doctor checking your prescription records in BC on your PharmaNet profile By signing below, you indicate that you have had an opportunity to discuss the clinic rules, you understand the rules, and you agree to abide by them.

**Clinic Policies:**

 Signing the line below acknowledges you have read, understood, and agree to the conditions listed out in the Clinic Policy and Patient Agreement, available online at [www.elicare.ca/lougheedfamilypractice](http://www.elicare.ca/lougheedfamilypractice). If you have questions, please talk to a staff member.

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_