# New Patient Form

life Medical Clinic

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|---|---|---|---|
| | | | Date: dd/mm/yyyy |
| First Name: | Last Name: | Preferred Name: | ☐ M ☐ F |
| Home Phone: | Cell Phone: | Work Phone: | |
| Preferred Contact umber ☐Home Phone ☐Cell Phone ☐Work Phone | | | |
| Address: | | Date of Birth: dd/mm/yyyy | Age: |
| City: | Postal Code: | Email: For Referrals and apt. confirmations-no spam emails | |
| AHC #: | Out of Province #: | Prov: | Smoking/Nicotine Status: ☐ Yes ☐ No Since: |
| Occupation: | | | Marriage Status: ☐ Single ☐ Married ☐Separated |
| Previous Family Physician: | | | Location: |

Past Medical History (Asthma, Hypertension, Diabetes etc.) Please include year of diagnosis, if possible.

| History | Year | History | Year | History | Year |
|---|---|---|---|---|---|
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Please indicate past surgeries and dates of screening tests
(colonoscopy, mammogram, cholesterol testing, PAPs or fecal occult blood test (FIT))

| Surgery | Year | Screening test | Year |
|---|---|---|---|
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Do you take any Medications? If so list them including contraceptives/vitamins.

| Medications | Medications |
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Do you have any allergies to medications, or environmental allergies?

| Allergies | Type of reaction |
|---|---|
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| | |

Do you have any family history of Cancer, Diabetes, Heart Disease, etc?

| Issue | Relation (maternal and paternal) |
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**Office Use Only**

| | | |
|---|---|---|
| Height: _____<br>Weight: _____<br>BP: _____ Pulse: _____ | Screening required<br>☐ PAP<br>☐ Mammogram<br>☐ FIT<br>☐ Colonoscopy<br>☐ Labs | Key<br>3 yrs ( >21)<br>2 yrs (>50)<br>2 yrs (>50)<br>family Hx, or symptoms<br>Diabetes, Lipids (>40) |