Joshua Creek Medical

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# NEW PATIENT APPLICATION FORM

Thank you for taking the time to fill out this application. Completion of this form does not guarantee registration at our clinic. Once the completed form has been submitted and reviewed, our front desk staff will contact you to arrange for a Meet & Greet appointment. Please be truthful and complete the application in its entirely. Failure to do so will delay the processing of your application. Please write N/A if a question is not applicable to you.

Last Name: _____ First Name: _____ Preferred Name: _____

Health Card No (including Version Code): _____

Date of Birth (mm/dd/yyyy): _____ Sex (M/F/other): _____Preferred pronoun: _____

Home address: _____

Preferred phone #: _____

Emergency Contact (including name, relationship, phone number): _____

Previous Family Doctor's Name, Phone Number & Fax Number: _____

_____

Reason for changing doctors: _____

Would you like to make Joshua Creek Pharmacy your Preferred Pharmacy? Yes ☐

If no, please provide your preferred pharmacy details
_____

_____

Allergies (please include name of medication or food, type of reaction, and age of onset): _____

_____

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# Medical History

Please list the CONFIRMED medical or mental health problems that you have been diagnosed with by a health care professional, if any. Write N/A if you do not any have confirmed diagnoses.

| Diagnosis | Year of Diagnosis | Name of Specialist (if any) |
|---|---|---|
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Do you have any NEW problems or health concerns that have not been addressed? Write N/A if none.

_____

_____

# Surgeries & Procedures

Please list any surgeries you have had in the past, including any miscarriages, abortions or cesarean sections. Write N/A if none.

| Surgery | Date (dd/mm/yy) | Where | Name of Surgeon |
|---|---|---|---|
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# Medication List

Please list any CURRENT medications that you are taking, including prescription medications, over-the-counter medications and supplements. Write N/A if none. **Please bring ALL your medications on your first visit. If you are on MORE THAN 3 medications, please have your pharmacist fax us a "Medications Check".**

| Medication Name | Dosage | Frequency | Year Started |
|---|---|---|---|
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# Preventive Screening

Please note that the following applies to certain age groups and risk factors.

| Screening test | When was the most recent test (mm/yy) | Result (normal or abnormal) |
|---|---|---|
| Pap Smear | | |
| Fecal Immunochemical Test (stool test) | | |
| Mammogram | | |
| Colonoscopy | | |
| Bone Mineral Density | | |

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# Immunizations

Please note that some immunizations are given to people of certain age groups and risk factors. Some of these questions may not apply to you. **For children up to age 18, please enclose all the immunizations as a copy of their immunization record.**

When was your last tetanus shot (every 10 years)? _____

Have you had the HPV vaccine (e.g. Gardasil)? ❑Yes ❑ No When?_____

Do you get the yearly flu shot? ❑Yes ❑ No

Have you had the pneumonia shot (for over 65 years old)? ❑Yes ❑ No When?_____

Have you had the shingles shot? ❑Yes ❑ No When?_____

# Social & Lifestyle History

What is your occupation?_____

What languages do you speak? _____

Do you require a translator? ❑ Yes ❑ No

Alcohol: Use Do you drink alcohol? ❑ No ❑ Yes If Yes, How many drinks/week:_____

Cigarettes: Do you smoke cigarettes? ❑ No ❑ Yes If Yes, How many cigarettes/day:_____

Caffeine: On average how many caffeinated beverages do you drink a day? _____

Recreational Drug Use? ❑ Yes ❑ No If yes, please give details per use: _____

Are you have ODSP, OW, or Trillium coverage ? ❑ Yes ❑ No If yes, which one? _____

Do you have private drug coverage? ❑ Yes ❑ No

Form completed by:

_____

Patient Name Date Signed Signature