Patient Demographic Data

Please help save time by completing this form before your first office visit. If you have received this form by email, you may complete the form on line using Adobe Acrobat and simply email it back to us. Please note that the information you provide is kept in a confidential database, which is protected from access by unauthorized persons.

Last name……First name…….Middle initials……

Title Mr. ○ Mrs.○ Ms.○ Miss○ Dr.○ Other…….

Street address (Apt, Street)…….....City……...Postal code……

'Phones: Home……..Work ……Ext……Mobile/cell phone(s).....

Email address(es) (*see 'consent to use email'*)……

Date of Birth (yyyy-mm-dd) ……..Male○ Female○ Other……..

Health Insurance Number……Province…… Driver's license number…….

.Your next of kin (emergency contact) Name/Relationship…….

Emergency contact number and address……

If appliocable:

RCMP numbers……..DND number…….. Veterans Affairs number……..

Pilot's License Number…….**(the Aviation Act requires pilots to notify all physicians that they are pilots)**

Your Medical and Surgical History

Your ***current*** medications

Name of drug	Strength	Directions	Date last prescribed

Your medication ***allergies*** and ***adverse reactions***

Name of drug	Type of reaction	Year

List over-the-counter and 'herbal' remedies and vitamins

List all current and past* medical conditions / illnesses	
List all operations and Procedures	
List all immunizations with dates	

If possible please provide a copy of your immunization record

Family history

Check all that apply

Father: Name…….Age…….(if deceased check☐….and state cause of death……..)

Health problems*:

Mother: Name…….Age…….(if deceased check☐….and state cause of death……)

Health problems*:

Siblings: How many?.....Health problems*

Other significant family medical history:

***Examples may include: Heart disease, Lung disease, Diabetes, Thyroid, Alcohol/drug abuse, Cancer (specify type), Mental disorder (specify type), Neurological disorders, Arthritis, Skin disorders, Infectious diseases including tuberculosis**

Social/Personal History and Background

Single○ Married○ Partnership○ Divorced○ Widowed○ Sexual preference: Hetero○ Bi○ Gay○ Lesbian○

Number of alcoholic beverages consumed in a *typical* week: total:…….wine……beer…….spirits……..

	Yes	No
Have you ever felt the need to cut back on your consumption of alcohol?.....	○	○
Have you ever felt angry or irritated when questioned about your use of alcohol?.....	○	○
Have you ever felt guily or embarrassed about the amount of alcohol you consumed?.....	○	○
Have you ever felt the need for a morning 'eye-opener' drink (of alcohol)?.....	○	○

How many cigarettes do you smoke a day?..... For how many years have you been smoking?.....

If you quit smoking, how many years ago?..... If you are still smoking are you motivated to quit? Yes○ No○

Do you use recreational drugs? No○ Yes○ Which?.....

Do you belong to a church, religion or failth? Yes○ No○ Which?.....

Does your religion have requirements that might affect the way your medical care is provided? Yes○ No○

If yes, please specify……Present/Past occupation(s)……. Retired Yes○ No○

Have you ever ***injected*** recreational drugs? Yes○ No○ Have you been tested for Hepatitis C? Yes○ No○

Education: Less than Grade 12 (or equivalent)○ Grade 12○ Trade○ College/University○ Other…….

Please list your sports and other physical recreational activities:

Please list your hobbies and interests:

Nutrition: Please look at a clock or watch and then record everything you've had to eat in the past 24 hours:

Please use this space to add any additional information that will help me to better serve your needs:

Name Date