FORT ST. JOHN FAMILY PRACTICE ASSOCIATES
10011 – 96th Street Fort St. John, BC V1J 3P3 Tel: (250) 785-6677 Fax: (250) 787-0109

NEW PATIENT - PLEASE FILL OUT FORM AND RETURN TO CLINIC RECEPTIONIST

FULL NAME _____ **BIRTHDATE** month/day/yr _____/_____/_____ **AGE**_____

NAME YOU PREFER TO BE CALLED _____ **SEX** male_____ female_____ (**as legally shown on your government ID**)

ADDRESS_____ **CITY**_____ **POSTAL CODE**_____

HOME#_____ **CELL #**_____ **WORK #**_____

PREFERRED NUMBER FOR APPTS, REFERRALS? HOME CELL WORK **EMAIL**_____

PHARMACY_____ **CARE CARD #**_____

EMERGENCY CONTACT_____ **PHONE #** _____ **RELATIONSHIP**_____

PREVIOUS FAMILY DOCTOR _____ (**please sign release form to have previous records sent to your new family doctor)**

MEDICATIONS (**list all prescription & over the counter medicines, vitamins, minerals, herbs you currently take**)

_____

MEDICAL HISTORY HAVE YOU HAD ANY OF THE FOLLOWING? (CIRCLE)

ANEMIA	RHEUMATIC FEVER	HEART ATTACK
HEPATITIS/LIVER DISEASE	KIDNEY STONES	HIGH BLOOD PRESSURE
HAYFEVER	HIV/AIDS	PNEUMONIA
TUBERCULOSIS	MIGRAINE/HEADACHES	BLADDER ISSUES
STOMACH ULCER	MUMPS	GYNECOLOGICAL ISSUES
BLOOD CLOTS	ARTHRITIS/RHEUMATISM	ABNORMAL PAP TEST
GALLBLADDER PROBLEMS	HIVES	PROSTATE PROBLEMS
ANGINA/CHEST PAIN	THYROID PROBLEMS	BLEEDING TENDENCIES
POLIO	HEART DISEASE	MONONUCLEOSIS
STROKE	DIABETES	ECZEMA
EPILEPSY	ALCOHOL/DRUG ABUSE	DEPRESSION/ANXIETY
CHRONIC PAIN	MENTAL HEALTH ILLNESS	BOWEL ISSUES
COPD/ASTHMA	COLITIS	EATING DISORDER
HEPATITIS	MEASLES	CANCER

SURGERIES (YEAR & TYPE) _____

_____

_____

_____

HOSPITALIZATIONS (YEAR & REASON) _____

_____

_____

INJURIES/ACCIDENTS (YEAR & CAUSE) _____

_____

EXTRA INFO_____

_____

FAMILY HISTORY INCLUDE BLOOD RELATIVES ONLY

FATHER (age)*_____BROTHERS (ages)*_____

MOTHER (age)*_____SISTERS (ages)*_____

If deceased, please list age at death and cause

ANY FAMILY HISTORY OF THE FOLLOWING? (CIRCLE)

DIABETES	KIDNEY DISEASE	STOMACH ULCERS
HEART DISEASE	ASTHMA	HIGH BLOOD PRESSURE
ALLERGIES	ARTHRITIS	NERVOUS BREAKDOWN
GOUT	COLITIS	BLEEDING TENDENCIES
ALCOHOLISM	TUBERCULOSIS	PSYCHIATRIC ILLNESS
CANCER	STROKE	GALLBLADDER PROBLEM

WOMEN ONLY CHILDBIRTH HISTORY

NUMBER OF CHILDREN _____ AGES _____

NUMBER OF PREGNANCIES _____ DELIVERIES_____

MISCARRIAGES _____ ACCIDENTAL _____ INDUCED_____

COMPLICATIONS _____

BIRTH CONTROL METHODS: IN PAST _____

NOW _____

ARE YOU PREGNANT AT THIS TIME ? _____

ALLERGIES(**include medicines, pollens, animals, foods & chemicals)**

_____

Are you currently without a family doctor and are requesting to be attached to our clinic for ongoing health care needs and intend to use this family physician as the sole provider for your care (other than emergency situations)?

Yes No

Signature_____ **Date**_____