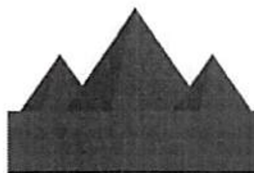

PH: 778-755-0700
Fax: 778-755-0705
#202 - 525 HIGHWAY 97 SOUTH
WEST KELOWNA, BC V1Z 4C9

PATIENT INFORMATION AND REGISTRATION

Patient Details

Last name: ____________ First name: ____________ Middle name: ____________

Preferred name: ____________ ☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Other: ____________

Health Care Number: ____________ Province: ☐ BC ☐ Other: ____________

Date of birth (YYYY/MM//DD): ____________ Gender: ☐ Male ☐ Female ☐ Trans ☐ Prefer not to say

Street address: ____________ City: ____________ Postal code: ____________

Home phone : ____________ Cell phone : ____________ Occupation: ____________

Email address: ____________ Emergency contact person: ____________

Relationship to patient: ____________ Contact's phone number/s : ____________

Medical History

Do you currently have a family doctor? ☐Yes ☐ No

If yes, doctors name: ____________ Clinic name/location: ____________

Are you taking any prescription/non prescription medication or supplements? ☐Yes ☐ No If yes, please list below:

Medication & Dosage: ____________ Medication & Dosage: ____________

Medication & Dosage: ____________ Medication & Dosage: ____________

Medication & Dosage: ____________ Medication & Dosage: ____________

Are you allergic to or do you have adverse reactions to any medications? ☐ No ☐ Aspirin ☐ Codeine ☐ Ibuprofen

☐ Morphine ☐ Penicillin ☐ Sulfa ☐ Other: ____________

Do you have any non-drug allergies (hay-fever, latex, food etc.)? ____________

Do you smoke? ☐Yes ☐ No If yes, what & how much per day? ____________

Are you pregnant? ☐Yes ☐ No If yes, what is your expected due date? ____________

Do you have extended medical benefits? ☐Yes ☐ No If yes, through which provider? ____________

Please list any past surgical procedures and year: ____________

____

Current/ Past Health Issues - please mark all that apply:

☐ Artificial Joints	☐ Asthma	☐ Blood Disorder	☐ Bronchitis	☐ Cancer
☐ Chronic Pain	☐ Diabetes	☐ Digestive Issues	☐ Emphysema	☐ Epilepsy
☐ Fibromyalgia	☐ Frequent UTI's	☐ Gallbladder	☐ Hearing Loss	☐ Heart Disease
☐ Hepatitis A B C	☐ High Blood Pressure	☐ High Cholesterol	☐ HIV positive	☐ Kidney Disease
☐ Low Blood Pressure	☐ Liver Disease	☐ Lung Disease	☐ Mental Health	☐ Headaches/Migraines
☐ PCOS	☐ Pneumonia	☐ Sinus Problems	☐ Sleep disorder/s	☐ Stroke
☐ Thyroid Condition	☐ Ulcers	☐ Other, not listed: ____________		

Would you like your consult sent to your GP? ____________

Patient/Guardian Signature: ____________ Date: ____________

If signing on behalf of the patient, please indicate name and relationship: ____________

BRITISH COLUMBIA | Ministry of Health

APPENDIX 1

PHARMANET
Patient Consent to Access PharmaNet

The Province of British Columbia has established the provincial computerized pharmacy network and database known as "PharmaNet" pursuant to section 13 of the *Pharmacy Operations and Drugs Scheduling Act*, S.B.C., 2003, c. 77.

Only the patient or their legal representative may sign this form. It is not acceptable for a caregiver of the patient who is not the patient's legal representative to sign the form on behalf of the patient.

☐ Check this box if you are the legal representative of the patient. ______________________
Nature of legal relationship with the patient

I, ____, authorize Dr.(s)
Name of Patient (if applicable, Legal Representative) (print)

Name of Physician(s)	Name of Physician(s)	Name of Physician(s)
Dr. Peter Warren		
Dr. John McNern		

and persons directly supervised by him/her to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me. I understand that withdrawal of this consent must be in writing and delivered to the above-named physician(s).

Executed at West Kelowna, BC, this ______ day of ________________, 2020 .

SIGNED AND DELIVERED by

____
Patient or Representative (signature)

in the presence of:

____
Witness (signature)

____
Witness (print)

This form is to be retained by the applicant and is not to be returned to the Ministry of Health.