MEDICARE CLINIC
101-1912 Enterprise Way, Kelowna, BC. V1Y 9S9
Tel: 250-872-2345 Fax: 833-999-1951

PATIENT INTAKE HISTORY

DATE:__________________

***LEGAL NAME**:_______________________________________**PREFERRED NAME:**_________________
(LAST NAME, FIRST NAME and MIDDLE NAME)

***DOB:**______________________________ (DD-MMM-YYYY)

***PHN:**____________________________________ (Personal Health Number – Care Card)

GENDER: ___________________ ***EMAIL:** ____

HOME ADDRESS: ____

PREFERRED PHARMACY:____

PREVIOUS FAMILY PHYSICIAN: ____
Reason for seeking a new GP: ____

Do you have a family member (name) in our clinic____

PHONE NUMBERS (list all contact information)**:**
Home:_________________________Cell:__________________________Work:_________________________

EMERGENCY CONTACT:____
(NAME, **RELATIONSHIP** and phone number)

MEDICATIONS: (please list all medications including vitamins, herbals, etc.)_________________________
____
____

ALLERGIES: (please list all allergies including medication, environmental, food, etc.)____________________
____

HABITS: Smoker______Yes How many cigarettes per day?____________________________________
______No When did you quit smoking?_____________________________________

Alcohol______Yes How much per day_________ per week__________ per month_________
______No When did you quit?____

Height:_____________________________ Weight:____________________________________

MEDICAL HISTORY: (check all that apply)

☐ Arthritis ☐ Asthma ☐ Anemia ☐ Back Pain
☐ Bronchitis ☐ Cancer___________ ☐ Chest Pain ☐ Chronic Pain
☐ Constipation ☐ Depression ☐ Diabetes ☐ Diarrhea
☐ Heartburn ☐ Hypertension ☐ Migraines ☐ Coronary Artery Disease
☐ Osteoporosis ☐ Seizures ☐ Sinus Problems ☐ Stress Incontinence
☐ High Cholesterol ☐ Weight Gain ☐ Anxiety ☐ Stroke

☐ Atrial fibrillation ☐ Recurrent UTI ☐ BPH ☐ Low Ferritin
☐ Other (please list) ____

____

____

WOMEN: Live Births_____________ Miscarriages_________
Pregnancies___________ LMP ___________________

SURGICAL HISTORY: (check all that apply and list the approximate year)

☐ Tonsillectomy __________ ☐ Appendectomy ___________

☐ Hysterectomy __________ ☐ Hysterectomy and Bilateral Oophorectomy __________

☐ Cataract Surgery __________ ☐ Hernia repair ___________

☐ Bypass Surgery _________ ☐ Surgical Fixation of a Fracture ___________

☐ Knee Replacement _________ ☐ Carpal Tunnel Release ___________

☐ Hip Replacement __________

☐ Other (please list) ____

____

FAMILY HISTORY: (check all that apply)

☐ Epilepsy ☐ Migraine ☐ Mental Illness ☐ Glaucoma

☐ Diabetes ☐ Thyroid Disease ☐ Hay Fever ☐ Asthma

☐ Anemia ☐ Bleeds Easily ☐ Osteoporosis ☐ Arthritis

☐ Heart Disease ☐ Stroke ☐ Hypertension ☐ High Cholesterol

☐ Alcoholism ☐ Hepatitis ☐ Cancer ☐ Depression

☐ Other (please list) ____

____

PERSONAL and SOCIAL HISTORY

☐ Unemployed/Disabled/on disability benefits ________

☐ Employed (occupation) ________________

☐ Student (school) ___________________ ☐ Retired (past job) ________________

☐ Marital status ________________

PREVENTIVE SCREENING TEST: (check all that apply and list the approximate year)

☐ MAMMOGRAM (Ages 40-74) _________

☐ FIT TEST (Ages 50-74) _________

☐ PAP (Ages 25-69) _________

☐ Colonoscopy _________

☐ Lung Cancer Screening /CT (for smokers Ages 55-74________

☐ Bone Mass Density ________

☐ Last Labs _________

INSURANCE CLAIMS (ICBC/WSBC): (Describe injury and indicate the approximate year)

☐

____

☐

____

PLEASE NOTE THAT BY COMPLETING AND SUBMITTING THE PATIENT INTAKE FORM DOES NOT AUTOMATICALLY MAKE YOU A PATIENT AT THIS CLINIC. THERE ARE LIMITED OPENINGS AT THIS TIME AND ONLY ACCEPTED PATIENTS WILL BE CONTACTED WITHIN A WEEK AFTER AN INITIAL MEET AND GREET WITH A FAMILY PHYSICIAN. DO NOT TRANSFER YOUR MEDICAL RECORDS UNTIL REQUESTED IF YOU ARE ACCEPTED AS A PATIENT. THE REMAINDER WILL BE ON OUR WAIT LIST.

By signing this document, you are certifying that the information is accurate and consent to virtual communication system.

DATE OF SIGNING:

PRINTED NAME OF PATIENT/GUARDIAN:

SIGNATURE OF PATIENT/GUARDIAN:

Ministry of Health

PHARMANET
Patient Consent to Access PharmaNet

The Province of British Columbia has established the provincial pharmacy network and database known as "PharmaNet" pursuant to section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act,* R.S.B.C. 1996, c. 363, and which may be continued pursuant to section 13 of the *Pharmacy Operations and Drugs Schedule Act,* S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

I,_________________________________, authorize _____________________
Name of Patient (print) *Name of Physician (print)*

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.

Executed at__________________________, this________day of________________, 20____.

SIGNED AND DELIVERED by)

_______________________________________)
Patient (print))

in the presence of:)

_______________________________________) _____________________________
Witness (signature)) *Patient (signature)*

_______________________________________)
Witness (print))

_______________________________________)
(Dated))

Practice Information–*please keep*

Appointments
Appointments can be made in person at the office or by calling the office phone number. We are currently working on online booking. In order to make sure we can book an adequate time for your appointment - we will ask you at the time of booking what concern/reason you are asking to be addressed. Alert us if there will be any paperwork involved as this may require more time.

Late Policy:
Call the practice if you are running late for a scheduled appointment to enable us to accommodate you on the same day or reschedule based on urgency.

Cancellation Policy:
We would like at least 24 hours for cancellation. If the practice needs to reschedule your appointment for any reason, efforts will be made to have you scheduled on the earliest available slot.

Controlled Medication:
If you are on high doses of opiates, benzodiazepines, or hypnotics it is expected that you are open to conversations regarding safe practices and willing to work together to lower these medications to a safer dose according to the college guidelines and best standard of practice. We do not abruptly discontinue long term medication without a plan that is safe for the patient.

Chaperon:
Our physicians are required to have a chaperon when performing sensitive procedures and examinations. As required by the CPSBC, they can also be required to be present at all/some patient interactions (clinic visit/ telephone) as deemed by the provider and circumstances.

Prescription Renewals:
If you take regular medication, do not allow yourself to be completely out before notifying your doctor. Endeavour to book appointments for renewals, and if we receive a refill notification from your pharmacy, we will be booking a phone call appointment for this. Drug prescribing of benzodiazepine and opiates: The practice has a policy not to issue repeat prescriptions for benzodiazepine medications such as Diazepam, Temazepam, clonazepam, zopiclone and opiates. Anyone in need of such medication on a regular basis will be reviewed more frequently and where necessary, discussion will be held regarding ongoing use.

Termination of the Physician-Patient Relationship:
Be aware that termination of the physician-patient relationship may occur in the following situations:

1. Harassment and/or violence towards staff, physician or other patients.
2. Significant breakdown in the physician-patient relationship, including irremediable differences in philosophy of care.