MOUNTAIN VALLEY MEDICAL

New Patient Intake Questionnaire Form

1715 ELLIS STREET KELOWNA, BC. V1Y 8M9, Canada
T: 250-763-7701 F: 250-763-7849

The purpose of this questionnaire is to ensure that your medical record contains complete information to enhance optimal care. Please fill in the relevant sections to the best of your ability and return to the clinic upon completion. Information provided are kept confidential. Ensure to sign the patient consent to Access Pharmanet and submit along with form. Once received we will contact you with a New Patient appointment date & time.
Priority will be given to patients without a local Family physicians or patients of retired Family physicians.

Date this form was completed: _____

Full Legal Name: _____

Preferred First Name: _____

Date of Birth: _____ BC Health Card Number: _____

Primary Phone: _____ Alternate Phone: _____

Email: _____ Preferred Pharmacy: _____

Address: _____

Emergency Contact Name and number: _____

Do you have any family members in our clinic? _____

Previous Family Physician: _____

Medical History

Height: _____ Weight: _____

CURRENT HEALTH CONCERNS
(Please list any significant medical problems that you are currently concerned about)

PROBLEMS	DATE OF DIAGNOSIS	COMMENTS

Do you see any Specialist doctors? Please list their name and specialty:

List any specialist doctors seen	Specialty	Year and reason for seeing

MEDICATIONS AND ALLERGIES –
(PLEASE NOTE – THE DOCTORS AT THIS OFFICE DO NOT PRESCRIBE NARCOTIC MEDICATIONS TO NEW PATIENTS)

What allergies do you have - medications or substances (attach a list for additional items):

1. _____ Type of reaction: _____
2. _____ Type of reaction: _____
3. _____ Type of reaction: _____

What medications and supplements do you take? (Attach a list for additional items)

(If you are unsure or unable to list - please bring all your medications to your first appointment):

1. _____ Strength: _____ Dosage: _____ For: _____
2. _____ Strength: _____ Dosage: _____ For: _____
3. _____ Strength: _____ Dosage: _____ For: _____
4. _____ Strength: _____ Dosage: _____ For: _____
5. _____ Strength: _____ Dosage: _____ For: _____
6. _____ Strength: _____ Dosage: _____ For: _____
7. _____ Strength: _____ Dosage: _____ For: _____
8. _____ Strength: _____ Dosage: _____ For: _____
9. _____ Strength: _____ Dosage: _____ For: _____

Operations/Procedures

Type of Operation or Procedure	Hospital/ City	Year

Immunizations: (Please include dates if known)

Tetanus within past 10 years:_____

Pneumonia: _____

Shingles: _____

COVID Vaccines (Y/N): _____

Childhood Immunizations (Y/N):_____

Hospitalizations

Name of Hospital	Hospital/ City	Year

Insurance Claims (ICBC/WSBC)-Current or Past Problems/Injuries

Description of Problem or Injury	Outcome	Year

Women's Health (if applicable):

Number of Pregnancies: _____

Number of Children: _____

Last Menstrual period: _____

Miscarriages:_____

Any obstetrical complications:_____

On Contraception/HRT: _____

Family History

SIGNIFICANT **FAMILY** HISTORY

(Please list any family history you have regarding the following conditions)

Health Problem	Yes	No	Relationship/ Approximate Age of Onset
Diabetes Mellitus	☐	☐	
High Blood Pressure (Especially under age 50)	☐	☐	
Stroke (Especially under age 50)	☐	☐	
Heart Attack (Especially under age 50)	☐	☐	
Heart Surgery or Bypass (Especially under age 50)	☐	☐	
Cancer- (What type and age)	☐	☐	
Thyroid Disease	☐	☐	

Respiratory condition	☐	☐	
High Cholesterol	☐	☐	
Parent Fractured Hip	☐	☐	
Mental Health Condition	☐	☐	

PREVENTION AND WELLNESS

Preventive Screening Tests (Please give approximate dates for the following)

***Women only: PAP and Mammogram**

(Ages 25-69) Date of last pap (recommended every 3 years): _____

(Ages 40-74) Date of last mammogram (recommended every 2 years): _____

Both:

Colon cancer screening-FIT or colonoscopy

(50-74 years old) Date of last stool test for colon cancer (recommended once a year): _____

If previous colonoscopy, state year and reason_____

Lung Cancer screening (For current/past smokers with >20years smoking history)

(55-74 years old) Date of last CT lungs test (recommended annually): _____

Bone Mass Density test for osteoporosis

(Women >65yrs) _____

(Men >70yrs) _____

Personal and Social History

Employed (occupation):_____Student (school): _____

Retired (past occupation):_____

Unemployed/Disabled/on disability benefits: _____

Marital status: Single, Partner, Married, Divorced, Widowed, other: _____

Lifestyle:

What best describes your diet:____VERY POOR____POOR____FAIR____GOOD____EXCELLENT

What best describes your present activity level: SEDENTARY MILD ACTIVITY AVERAGE ACTIVITY QUITE ACTIVE VERY ACTIVE

Tobacco:

What is your smoking status:____NEVER SMOKED____SMOKER____EX-SMOKER____PASSIVE SMOKE CONTACT

If smoking, Cigarettes – number/day:_____ Duration of smoking: Year Stopped:_____

Alcohol:

What best describes your drinking habits:_____NONE_____LIGHT_____MODERATE_____HEAVY_____EX-DRINKER

How many drinks per day on average:_____
Year Stopped:_____
Are you concerned about the amountyou drink?_____
Have you considered cutting down?_____
Are you prone to "binge" drinking?_____
Have you ever had a problem with alcohol?_____

Recreational Drugs:

What best describes your recreational drug use:_____NEVER_____EX-USER_____LIGHT_____MOD_____HEAVY

If yes, what drugs have you used?_____
How often do you usually use?_____ Date last used._____

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:

MOUNTAIN VALLEY MEDICAL

Practice Information

1715 ELLIS STREET KELOWNA, BC. V1Y 8M9, Canada
T: 250-763-7701 F: 250-763-7849

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 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 use to accommodate you on the same day or reschedule based on urgency.

Cancellation Policy:

We will 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/ televisit) 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 regularly 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.

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))