ACEPRO MEDICAL CLINIC
209 ASHER ROAD, KELOWNA, BC, V1X3H5
TEL: 250-491-1355 FAX:250-491-1171

NEW PATIENT INTAKE FORM

DATE:_____

SURNAME:_____ **FIRST NAME**:_____

DOB: _____ **PHN**:_____

GENDER: _____ **EMAIL**:_____

HOME ADDRESS:_____

PHONE NUMBERS: cell: _____ home:_____ work:_____

PREFERRED PHARMACY: _____

EMERGENCY CONTACT:_____
(Name, relationship, phone no)

DO YOU HAVE FAMILY MEMBERS WHO ARE ALREADY PART OF THIS CLINIC?
If yes, pls indicate name:_____

PREVIOUS FAMILY PHYSICIAN:_____

CURRENT MEDICATIONS: Please list all medications including contraceptives, vitamins, supplements

_____

_____

_____

ALLERGIES: Please specify all allergies including medications, food, environmental etc

_____

_____

MEDICAL HISTORY: check all that apply (pls specify year of onset)

Hypertension		Asthma		Osteoarthritis	
Diabetes		COPD		Osteoporosis	
High cholesterol		Migraine		Depression	
Coronary artery disease		Heartburn		Anxiety disorder	
Atrial fibrillation		Epilepsy		ADHD	
Previous stroke		Obesity		Rheumatoid arthritis	
Cancer_____		Iron deficiency		Thyroid disorder	
Dementia/ Alzheimer's		Endometriosis		Menstrual disorder	

Others: pls specify _____

_____

_____

SURGICAL HISTORY: Check all that apply (pls specify year of surgery)

Heart surgery- coronary stents		Hip Replacement- right/ left	
Heart surgery- cardiac bypass		Knee Replacement- right / left	
Abdominal surgery:_____		Surgical Fracture Fixation:_____	
Bariatric/Weight loss surgery		Hysterectomy +/- oophorectomy	
Carpal Tunnel Release		Bowel surgery	

Others: pls specify_____

_____

_____

FAMILY HISTORY: check all that apply (pls specify family members who had disorder)

Heart attack		High cholesterol	
Diabetes		Cancer_____	
Hypertension		Thyroid disorder	
Stroke		Blood disorders	
Alzheimer's disease		Asthma/COPD	
Migraine		Epilepsy	

Others:pls specify_____

_____

_____

GYNAECOLOGY / OBSTETRICS HISTORY (FEMALES)

Last Menstrual Period (LMP):_____ Cycle length:_____

Pregnancies- total number: _____ Live births: _____

Abortions/ Miscarriages: _____Contraception:_____

PREVENTIVE CARE CHECKLIST: pls check all that apply and list when last test was done

- ☐ Mammogram (40-74 yrs, 1-2 yearly)
- ☐ Pap test (25-69 yrs, usually 3 yearly)
- ☐ FIT test (50-74 yrs, 2 yearly)
- ☐ Colonoscopy
- ☐ Lung Cancer screen -low dose CT scan (55-74 yrs) if risk factors: > 30 pack/yrs, current smoking or quit less than 15 yrs ago)
- ☐ Bone Mineral Density (>/= 65 yrs or if at risk)
- ☐ Cholesterol test
- ☐ Glucose test

SOCIAL HISTORY

Employment status

- ☐ Employed(occupation)_____
- ☐ Unemployed, when last worked_____
- ☐ Disability, since when_____
- ☐ Retired, when_____
- ☐ Student (school)_____

Smoking: Cigarettes, Cigar, Tobacco chewing, vaping

- ☐ Yes–quantity/ week_____how long have you smoked for_____
- ☐ Past smoker- when did you quit_____
- ☐ No

Cannabis use: what type- edible, oils, smoking

- ☐ Yes, quantity/ week_____if medical use _____
- ☐ No

Alcohol use: wine, beer, spirits, coolers

- ☐ Yes, - quantity/week_____ quantity/ month_____
- ☐ No-, when did you quit

Diet:

- ☐ Restrictions eg gluten, others_____
- ☐ Vegetarian : specify_____
- ☐ Others: specify_____

Exercises:

- ☐ Sedentary
- ☐ Active : what type of exercises_____how frequently_____

INSURANCE CLAIMS:(active)

- ☐ WCB: describe injury/ date
- ☐ ICBC: describe injury, date
- ☐ Others : disability, insurance company

PLEASE NOTE THAT COMPLETING AND SUBMITTING THIS 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 TO SCHEDULE AN INITIAL MEET AND GREET WITH A FAMILY PHYSICIAN. PLEASE DO NOT TRANSFER YOUR MEDICAL RECORDS UNTIL AFTER YOU HAVE BEEN ACCEPTED AS A PATIENT.

BY SIGNING THIS DOCUMENT YOU CERTIFY THAT PROVIDED INFORMATION IS ACCURATE.

PRINTED NAME OF PATIENT/ GUARDIAN: _____
SIGNATURE:_____DATE SIGNED_____