Sorrento & Area Community Health Centre Society

New Patient Intake Form

Contact Information

Name: _____

Date of Birth: _____

Personal Health Number: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Emergency Contact

Name: _____

Relationship to Patient: _____

Phone Number: _____

Allergies

Medication/Substance	Reaction

Please list your present medications/supplements

Substance Use History

Do you currently smoke tobacco? _____ If no, did you ever smoke? _____

Year or age when you started _____ Year or age when you quit _____

What would you say your average use is/was_____

Do you currently vape nicotine?

Do you drink alcohol? _____

If so, how much do you drink per week_____

Do you use cannabis? _____ If so, do you smoke or ingest it? _____

If so, how much do you use per week/month? _____

Do you use any other recreational drugs_____

Health Questionnaire

Please complete the following questions to the best of your abilities and comfort level to enable us to get to know you faster. Circle your response or use the text box to complete your answers.

Have you been diagnosed with:

1) Eye problems such as glaucoma, cataract, macular degeneration?
2) Ear, nose or throat problems including hay fever, sinusitis, sore throat, or ear infections?
3) Cardiovascular problems such as high blood pressure, heart attack, heart failure, aneurysm, rhythm problems (atrial fibrillation or pacemaker)?
4) Respiratory problems such as asthma or COPD?
5) Digestive problems such as reflux disease, ulcers, colitis, diverticulitis?
6) Renal (kidney) problems including stones, cysts, prostate, bladder control?
7) Hematologic (blood) problems such as clots, lymphoma, anemia?
8) Endocrine (glandular) problems such as diabetes or thyroid disease?
9) Rheumatologic (joint) problems such as osteoarthritis, rheumatoid arthritis, lupus
10) Dermatologic (skin) problems such as psoriasis, eczema, lupus, hives?
11) Oncologic (cancer) of any location including breast, uterus, ovary, skin or prostate?
12) Mental Health concerns such as depression, anxiety, psychosis, or eating disorder?

Family History

Please list all past or current medical conditions of all your first-degree family members such as father, mother, siblings and/or children

Condition	Family Member
Cancer (include type and age)	
Sudden and unexpected death	
Heart Attack or Stroke, high blood pressure or high cholesterol	
Parent with a fractured hip	
Mental Health Concerns	
Other	

Please list any religious affiliations that may impact your medical decisions

In the past 5 years, have you been cared for by any specialists?

Name of Specialist	
Condition	

Name of Specialist	
Condition	

Name of Specialist	
Condition	

Do you have any other conditions/concerns you would like to us to know?
