

Patient Intake Form

Name and preferred pronouns:

PHN/Care Card:

DOB (DD/MM/YYYY):

Address:

Phone (Home/Cell):

Email:

Previous GP/Clinic:

Emergency Contact (Name/Relation/Phone):

Priority Concern:

Expectations from your new family doctor:

Social & Health History

• Occupation/Status:

• Extended health/drug coverage? Yes ☐ No ☐

• Tobacco/vaping? Yes ☐ No ☐

• Alcohol? Yes ☐ No ☐

• Cannabis? Yes ☐ No ☐

• Illicit Substances Used:

Cocaine ☐

Meth ☐

Heroin ☐

Psychedelics ☐

Family & Personal Medical History Immediate family history:

- Cancer:
- Heart disease:
- Diabetes:
- Hypertension:
- Autoimmune/congenital:

Past Medical Diagnoses:

Work Safe BC or ICBC open file: Yes ☐ No ☐

Surgical History:

Allergies:

Current Medications:

Mental Health History:

Signatures

Patient Name: Date:

Signature: Parent/Guardian (if applicable):