NEW PATIENT APPLICATION FORM

Thank you for taking the time to fill out this application. Once the completed form has been submitted and reviewed, our receptionist will contact you to arrange a Meet & Greet appointment. **Please be truthful and COMPLETE ALL SECTIONS OF THE APPLICATION. Write NOT APPLICABLE (N/A) if a question does not apply to you. FAILURE TO DO SO WILL DELAY THE PROCESSING OF YOUR APPLICATION.**

Last Name: ____________________ First Name: ___________________ Preferred Name: _______________

Health Card No: ____________________________Version Code:_________ Expiry Date: _______________

Date of Birth (dd/mm/yyyy): _____________________ Age: _________

Sex (M/F/non-binary): _____________________ Preferred Pronoun: ______________

Home Address: ____

Unit Number Street Address City Postal Code

Preferred Phone #: _____________________________ Alternative Phone #:____________________________

E-mail Address: ____

(please sign the E-mail Correspondence Consent Form)

Emergency Contact (including name, relationship, phone number): ___________________________________

Previous Family Doctor's Name, Phone Number & Fax Number: ____________________________________

____

Reason for Changing Doctor: ____

Preferred Pharmacy Name, Address, Fax Number: ____

____

Allergies (please include the name(s) of medication/food allergy, type of reaction, and age of onset):

____

____

Medical History

Please list CONFIRMED medical or mental health problems that you have been diagnosed with by a health care professional, if any. **WRITE N/A IF YOU DO NOT HAVE ANY CONFIRMED DIAGNOSIS.**

Diagnosis	Year of Diagnosis	Name of Specialist (if any)

Do you have any NEW problems or health concerns that have not been addressed? **WRITE N/A IF NONE.**

____

____

Surgeries & Procedures

Please list any surgeries you have had in the past, including any miscarriages, abortions or cesarean sections. **WRITE N/A IF NONE.**

Surgery	Date (mm/yy)	Where was this done

Medication List

Please list any CURRENT medications that you are taking, including prescription medications, over-the-counter medications and supplements. **WRITE N/A IF NONE.** Please be ready to discuss ALL of your medications on your first visit (i.e. have your medication pill bottles ready). If you are on MORE THAN 5 medications, please have your pharmacy fax us a "Medications Check".

Medication Name	Dosage	Frequency	Year Started

Preventive Screening

Please note that the following applies to certain age groups and risk factors**. WRITE N/A IF NONE.**

Screening test	When was the most recent test (mm/yy)	Result (normal or abnormal)
Pap Smear		
Stool Test (Fecal Immunochemical Test)		
Mammogram		
Colonoscopy		
Bone Mineral Density		

Immunizations

Please note that some immunizations are given to people of certain age groups and risk factors. Some of these questions may not apply to you. **For children up to age 18, please email Immunization Record to info@stockyardsmedical.ca BEFORE your appointment.**

When was your last tetanus shot (every 10 years)? ____________________________________

Have you had the HPV vaccine (e.g. Gardasil)? ❑Yes ❑ No When?____________________

Do you get the yearly flu shot? ❑Yes ❑ No

Have you had the pneumonia shot (i.e. Pneumovax, Prevnar)? ❑Yes ❑ No When?____________________

Have you had the shingles shot? ❑Yes ❑ No When?__________________________________

COVID-19 vaccine:
Dose #1 received? ❑ Yes ❑ No When?____________________ Type: ❑Pfizer ❑Moderna ❑AstraZeneca

Dose #2 received? ❑ Yes ❑ No When?____________________ Type: ❑Pfizer ❑Moderna ❑AstraZeneca

Social & Lifestyle History

What is your occupation?____

What is your ethnic background? ___________________ What language(s) do you speak? ____________________

Do you require a translator? ❑ Yes ❑ No

Alcohol: Use Do you drink alcohol? ❑ No ❑ Yes If Yes, How many standard drinks/week:_________________

Cigarettes: Do you smoke cigarettes? ❑ No ❑ Yes
If Yes, How many cigarettes/day:______________________ Onset of Use (Age): __________________________

Caffeine: On average how many caffeinated beverages do you drink a day? ______________________________

Recreational Drug Use (e.g. Marijuana)? ❑ Yes ❑ No
If yes, please provide name of substance, amount, frequency of use, and onset of use:

____

____

Do you have any dietary restrictions? ______________________________

Are you have ODSP, OW, or Trillium Coverage ? ❑ Yes ❑ No If yes, which one? ____________________

Do you have private drug coverage or benefits? ❑ Yes ❑ No

Form completed by:

____

Patient Name Date Signed Signature