New Patient Medical History and Intake Form

*Welcome to **Mahogany Medical**! We look forward to providing quality medical care for you. In order for us to better serve you, please kindly fill out the information below to the best of your knowledge.*

Date *(mm/dd/yyyy)*: ____________

DEMOGRAPHIC

First Name *(nickname if applicable)*: ____

Middle name: ___________________________ Last Name: _________________________________

Address: ____ Postal code: ________

Home Phone: _______________ Work Phone: _________________ Cell Phone: _______________

Sex: _______________________ Date of Birth *(mm/dd/yyyy)*: _________________________________

Alberta Health Care Number: ____

Emergency Contact Name: ____

Phone number: __________________________ Relationship: _________________________________

OTHER INFO

How did you hear about us? ____

Who was your previous family doctor? ____

Will you require your medical records be transferred from another clinic? YES NO

Would you like to receive clinic email updates? YES NO

Would you be interested in receiving text message appointment reminders? YES NO

Email address: ____

SOCIAL HISTORY

Your School / Place of work: ____

Your Grade / Occupation: ____

Marital Status: Single Common-Law Married Divorced Widowed

Partners Name: ____

Who lives at home with you? ____

ALLERGIES

Medication Allergy: _____________________________ Reaction: ___________________________

Medication Allergy: _____________________________ Reaction: ___________________________

Non-medication Allergy: __________________________ Reaction: ___________________________

Do you carry an Epi-Pen? YES NO

MEDICATIONS

Prescription medications:

Name	Frequency	Dose	Why do you take it?	How long have you been taking it?

Over the counter medications / supplements / vitamins / herbal remedies:

Name	Frequency	Dose	Why do you take it?	How long have you been taking it?

MEDICAL HISTORY

Past Medical History:

Condition	Year of diagnosis	Do you see a specialist for this	Active or Resolved?

SURGICAL HISTORY

Past Surgical History (please include wisdom teeth, LEEP, colonoscopy, eye surgery if applicable):

Date of surgery	Type of surgery	Reason for surgery

PRENATAL HISTORY

No. of pregnancies: ________________ No. of deliveries: ________________

No. of miscarriages: ________________ No. of terminations: ______________

When was your last PAP test ____________

Date	Hospital	Type of delivery	No. of weeks	Complications	Child's name

LIFESTYLE

Do you smoke? YES NO Cigarettes per day: ______________________

Years of tobacco use: ________________

Do you drink alcohol? YES NO Drinks per week: ________________________

Are you concerned about your alcohol use? YES NO

If you answered *YES* above please explain why: ____

____

____

Have you / do you use any recreational drugs? YES NO

Marijuana Cocaine Methamphetamine Heroin Other

FAMILY HISTORY

Is there any genetic / hereditary diseases known in your family? YES NO

Ie. High blood pressure, colon cancer, breast cancer, prostate cancer...

Relationship	Condition	Age of diagnosis	Living or Deceased