

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.



MAHOOGANY
MEDICAL CLINIC

Date (mm/dd/yyyy): _____

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: _____

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: _____

Marital Status: Single Common-Law Married Divorced Widowed

Partners Name: _____

Who lives at home with you? _____

Grade / Occupation: _____

School / Place of work: _____

Medication Allergy: _____ Reaction: _____

Medication Allergy: _____ Reaction: _____

Non-medication Allergy: _____ Reaction: _____

Do you carry an Epi-Pen? YES NO

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?

Past Medical History:

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

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

Date of surgery	Type of surgery	Reason for surgery

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

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

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