PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

FIRST NAME	LAST NAME	DATE OF BIRTH
ADDRESS AND POSTAL CODE		Please Circle: Male or Female
CARE CARD #	EMAIL	
HOME NUMBER	CELL NUMBER	WORK NUMBER
EMERGENCY CONTACT NAME AND PHONE NUMBER		
PAST MEDICAL AND SURGICAL HISTORY		
CURRENT MEDICATIONS/ VITAMINS/ HERBAL SUPPLEMENTS		
DO YOU SMOKE? IF YES, HOW MUCH?	DO YOU DRINK ALCOHOL? IF YES, HOW MUCH?	
DO YOU USE RECREATIONAL DRUGS? IF YES, WHICH ONES?		
ALLERGIES	OCCUPATION	
FAMILY HISTORY		
WHEN WAS YOUR LAST PAP? MAMMOGRAM?	WHAT VACCINATIONS HAVE YOU HAD IN THE PAST?	
WHAT IS THE REASON FOR YOUR VISIT TODAY?		
HEIGHT	WEIGHT	

If ICBC or WCB related:
CLAIM # _____ DATE OF ACCIDENT: _____