NEW PATIENT MEDICAL HISTORY FORM

PRINT PATIENT LABEL

ALLERGIES: □ NO KNOWN ALLERGY *(please check box)*

□
□
□
□
□

MEDICATIONS: PLEASE LIST ALL INCLUDING DOSE

□
□
□
□
□
□
□
□
□
□

FAMILY MEDICAL HISTORY □ NO SIGNIFICANT FAMILY HISTORY IS KNOWN *(please check box)*

(ie: Cancer, Heart Disease, Depression/Anxiety, Kidney Disease, Thyroid Disease, etc.)

Mother	
Father	
Brother	
Sister	
Other	

SURGERIES □ NO KNOWN SURGERIES *(please check box)*

TYPE	DATE	LOCATION/FACILITY

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	Yes	No	COMMENTS
Cancer *(type:_____)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Diabetes *(type:_____)*			
Pregnancy Complications *(hypertension, diabetes, preeclampsia, preterm labour, etc.)*			
Asthma			
Emphysema *(COPD)*			
Gastrointestinal Disease *(IBD, IBS, Reflux, Crohn's, Ulcerative Colitis, etc.)*			
Liver/ Gallbladder Disease			
Hypothyroidism/ Thyroid Disease			
Renal *(kidney) Disease*			
Stroke			
Migraine/Headaches			
Epilepsy/Seizures			
Parkinson's Disease			
Developmental Disorders *(ADHD, Learning, Speech, ASD, etc.)*			
Depression/Anxiety/Bipolar/Suicidal *(Please include hospitalizations for mental health/suicidal)*			
Osteoarthritis			
Inflammatory Arthritis *(Rheumatoid, Ankylosing Spondylitis, Psoriatic Arthritis, etc.)*			
Fibromyalgia			
Other:			

SOCIAL HISTORY
Employment Status: □ Employed □ Retired □ Unemployed □ Disabled *Please specify occupation:* _____
Extended Health Coverage? □ Yes □ No

Marital Status *(check one):* □ Single □ Partner □ Married □ Divorced □ Widowed □ Other:	
Do you have children? □ Yes □ No	If yes, how many?

OTHER HEALTH ISSUES			
TOBACCO USE	Smoke Cigarettes? □ Yes □ No *(If you never smoked, please move to Alcohol/Drug Use)*		
Current: *Packs/day _____ # of Years _____*	**Past:** *Quit Date: _____ Packs/day _____ # of Years_____*		
Other Tobacco *(check one):* □ E-Cigarette/Vape			
ALCOHOL/DRUG USE	Do you drink alcohol? *(Please Check)* □ Yes □ No	□ Beer □ Wine □ Liquor	# of drinks/week: _____
Do you use marijuana or recreational drugs? *(Please Check)* □ Yes □ No			
Have you ever used needles to inject drugs? *(Please Check)* □ Yes □ No			

Rideau Crossing Family Health Centre will collect, use, and disclose personal information in compliance with the Personal Information Protection and Electronic Documents Act (PIPEDA). Our policy at Rideau Crossing is to protect the privacy of individuals with respect to personal information in its custody and control.