Orleans Family Health Clinic
210 Centrum Blvd., Suite 101 & 110
Orleans, Ontario K1E 3V7
T: (613) 830-1771 F: (613) 830-2543

PERSONAL INFORMATION

Patient Name: ______________________________________ Date of Birth: ____/____/______ Age: ____

Gender: ____ Wt: ______ Ht: _____ Marital Status: ______________ Do you identify yourself as L G B T I

Occupation: ____

Emergency Contact
Name: _______________________________ Relationship: __________________ Phone: ________________

Specialists: ____

Other Health Care Providers: ____

MEDICAL INFORMATION

Primary Pharmacy & Phone Number: ____

Allergies, if known and reaction (medical, environmental, foods): __________________________________

Current List of Medication/s & dosage:

List of Vitamins and other over-the-counter medications:

Last serious conditions, illnesses, injuries and/or hospitalizations & dates:

Your general state of health: _____Excellent _____Good _____Fair _____Poor

Please list your health concerns, in order of importance to you:

1. ____ 3. ______________________________________

2. ____ 4. ______________________________________

Family Health History

Has a close relative (parent, grandparent, or sibling) had any of the following?

Arthritis		Cancer		Kidney Problems	
Tuberculosis		Stroke		Mental Health Issues	
Diabetes		Heart Problems		Multiple Sclerosis	
Epilepsy/Seizures		High Blood Pressure		Osteoporosis	
High Cholesterol		Lung Problems/Asthma		Thyroid Problems	

GENERAL HEALTH INFORMATION

Is there anything that you feel may be important for us to know?

____

____

Do you get regular screening tests done by another doctor? (PAP, blood tests, etc.) Y / N

Immunizations up to Date: Y / N

History of adverse reactions to immunizations: Y / N

Do you use any of the following? List the type and frequency if applicable:

	Alcohol			Laxatives	
	Antacids			Tylenol/Aspirin/Advil	
	Caffeine			Recreational drugs	
	Cigarettes				

Are you currently pregnant? Y / N

How many pregnancies have you had? _________________

Children & Age: ____________________________ How were they born ____________________________

Age: ____________________________ How were they born ____________________________

Last date of PAP: ___________________________