

FORT ST. JOHN FAMILY PRACTICE ASSOCIATES

10011 – 96th Street

Fort St. John, BC V1J 3P3

Tel: (250) 785-6677

Fax: (250) 787-0109

NEW PATIENT - PLEASE FILL OUT FORM AND RETURN TO CLINIC RECEPTIONIST

FULL NAME _____		BIRTHDATE month/day/yr ____/____/____		AGE ____
NAME YOU PREFER TO BE CALLED _____		SEX male ____ female ____ (as legally shown on your government ID)		
ADDRESS _____		CITY _____		POSTAL CODE _____
HOME# _____	CELL# _____	WORK # _____		
PREFERRED NUMBER FOR APPTS, REFERRALS? HOME CELL WORK EMAIL _____				
PHARMACY _____		CARE CARD # _____		
EMERGENCY CONTACT _____		PHONE # _____		RELATIONSHIP _____
PREVIOUS FAMILY DOCTOR _____ (please sign release form to have previous records sent to your new family doctor)				

MEDICATIONS (list all prescription & over the counter medicines, vitamins, minerals, herbs you currently take)**MEDICAL HISTORY HAVE YOU HAD ANY OF THE FOLLOWING? (CIRCLE)**

ANEMIA	RHEUMATIC FEVER	HEART ATTACK
HEPATITIS/LIVER DISEASE	KIDNEY STONES	HIGH BLOOD PRESSURE
HAYFEVER	HIV/AIDS	PNEUMONIA
TUBERCULOSIS	MIGRAINE/HEADACHES	BLADDER ISSUES
STOMACH ULCER	MUMPS	GYNECOLOGICAL ISSUES
BLOOD CLOTS	ARTHRITIS/RHEUMATISM	ABNORMAL PAP TEST
GALLBLADDER PROBLEMS	HIVES	PROSTATE PROBLEMS
ANGINA/CHEST PAIN	THYROID PROBLEMS	BLEEDING TENDENCIES
POLIO	HEART DISEASE	MONONUCLEOSIS
STROKE	DIABETES	ECZEMA
EPILEPSY	ALCOHOL/DRUG ABUSE	DEPRESSION/ANXIETY
CHRONIC PAIN	MENTAL HEALTH ILLNESS	BOWEL ISSUES
COPD/ASTHMA	COLITIS	EATING DISORDER
HEPATITIS	MEASLES	CANCER

SURGERIES (YEAR & TYPE) _____

HOSPITALIZATIONS (YEAR & REASON) _____

INJURIES/ACCIDENTS (YEAR & CAUSE) _____

EXTRA INFO _____

FAMILY HISTORY INCLUDE BLOOD RELATIVES ONLY

FATHER (age)* _____ BROTHERS (ages)* _____

MOTHER (age)* _____ SISTERS (ages)* _____

If deceased, please list age at death and cause**ANY FAMILY HISTORY OF THE FOLLOWING? (CIRCLE)**

DIABETES	KIDNEY DISEASE	STOMACH ULCERS
HEART DISEASE	ASTHMA	HIGH BLOOD PRESSURE
ALLERGIES	ARTHRITIS	NERVOUS BREAKDOWN
GOUT	COLITIS	BLEEDING TENDENCIES
ALCOHOLISM	TUBERCULOSIS	PSYCHIATRIC ILLNESS
CANCER	STROKE	GALLBLADDER PROBLEM

WOMEN ONLY CHILDBIRTH HISTORY

NUMBER OF CHILDREN _____ AGES _____

NUMBER OF PREGNANCIES _____ DELIVERIES _____

MISCARRIAGES _____ ACCIDENTAL _____ INDUCED _____

COMPLICATIONS _____

BIRTH CONTROL METHODS: IN PAST _____

NOW _____

ARE YOU PREGNANT AT THIS TIME ? _____

ALLERGIES(include medicines, pollens, animals, foods & chemicals)

Are you currently without a family doctor and are requesting to be attached to our clinic for ongoing health care needs and intend to use this family physician as the sole provider for your care (other than emergency situations)?

Yes**No**

Signature _____

Date _____