Silverado Medical Clinic

#806, 19369 Sheriff King Street SW Calgary, AB T2X 0T9

Tel: (403) 873-7300 Fax: (403) 873-8880

Patient Intake Form

Full Name: _____
(first) (middle) (last)

Health Care #: _____ Date of birth: (dd/mm/yy):_____ Gender: M/F Age:_____

Marital Status: ( ) Single ( ) Married ( ) Common-Law ( ) Separated ( ) Divorced ( ) Widowed

Address:

Home Phone: _____ Cell/Alternate: _____

Email:_____ Do you want to register for online booking? ( ) YES ( ) NO

Best way to contact you during the day:_____

Best way to contact you on evenings/weekends:_____

HEALTHCARE INFORMATION

How long have you been without a family doctor?

( ) Less than 6 months ( ) 6 months to 1 year ( ) 1 to 2 years ( ) More than 2 years

Name of your pharmacy:_____ Pharmacy phone #: _____

Name of your last family physician:_____ Clinic name:_____

Clinic phone #: _____

HABITS & SCREENING INFORMATION

Periodic screening is an important part of health maintenance. There are certain teststhat can identify serious diseases early on, increasing your chances of successful treatment. Please answer the following questions.

Smoker: ( ) NO ( ) YES: # of cigarettes per day:_____ Since(YYYY): _____
If you WERE a smoker, when did you quit? (MM/YY):

Have you had a **blood sugar** test : ( ) NO ( ) YES (YYYY):

Have you had a colonoscopy (50 years or older)? ( ) NO ( ) YES (YYYY):

Alcohol Intake: ( ) I don't drink alcohol

- If you do drink alcohol: _____ # of drinks/week
- If you don't drink weekly: _____ # of drinks/month

Did you have your **childhood vaccinations**?: ( ) Yes ( ) No

When was your last **tetanus shot**? (YYYY):

Pneumonia shot? ( ) No ( ) Yes (YYYY):

FEMALE PATIENTS ***(21years or older)***

Pap (MM/YY): _____ ( ) Haven't had one

Breast Exam (MM/YY):_____ ( ) Haven't had one

Mammography (MM/YY):_____ ( ) Haven't had one

# of pregnancies (please include abortions, miscarriage):

How many children do you have?

MALE PATIENTS ***(50 years or older)***

Prostate exam (MM/YY):_____ ( ) Haven't had one

PSA Test (MM/YY): _____ ( ) Haven't had one

CLINICAL INFORMATION

Medical Condition(s)	Specialist Name	Current Medication(s) and dosage:

Intolerance /Allergies (please describe reaction) : _____ **( ) NONE**

_____

_____

Have you had any surgery? ( ) NO ( ) YES

List of surgeries and date(MM/YY):

FAMILY HISTORY

Specify diagnosis and which side of the family (motheror father)

	Diabetes (Type I or II)	High Blood Pressure	Heart Disease	Aneurysm	Cancers (Please specify type)	Mental illness (Please specify)
Mother / Mother's Relatives						
Father / Father's Relatives						
Siblings or Your Children (Specify which)						

EMERGENCY CONTACT

Name of contact: _____ Relationship to you: _____

Home phone #: _____ Alternate phone #: _____

The above information is true to the best of my knowledge.

Patient Signature (parent / guardian if applicable): _____ Date (dd/mm/yy): _____