Mission Oaks Medical Centre

Appointment Form

Please complete all sections on this page. Please print.

Today's date: _____

Patient Information - As it appears on your care card

Patient's Last Name	First :	Middle:	Mr/ Mrs / Miss/ Ms / Dr	Marital Status:

Is this your legal name?	If not, what is your legal name?	(Former name):	Age:	
☒ Yes ☐ No				☐ M ☐ F

MSP Number:		Birth Date: YYYY / MM / DD	Home telephone:
Address		Cell Number:	Work telephone:

Occupation:	Employer:	

Email address:

PREFERED DOCTOR

☒ Dr K. Aneja	(female, Punjabi speaking)	☐ Dr. H. Dau	(male, Punjabi speaking)
☐ Dr. E. Barnsdale	(female)	☒ Dr. L . Kamal	(female, Punjabi speaking)
☒ Dr. P. Barnsdale	(male)	☐ Dr. F. Rahimi	(male, German, Farfis speaking)
☒ Dr. J. Pretorius	(male, Afrikaans speaking)	☐ Dr. L . Juadiong	(female)
☐ Dr. A. Mortimore	(female)	☐ Crystal Zaghloul, NP	(female)

Who is your current family doctor? If a Mission doctor, reason for change.

Language Spoken:

If you do not speak English, you are responsible for bringing a family member to interpret.

The following three pages consist of a general health questionnaire.
Completion of the health questionnaire is optional.
The health questionnaire will become part of your medical record.
We would ask you to complete as many of the sections as you feel comfortable answering.
All information provided is strictly confidential.
The Mission Oaks Medical Centre front staff will be happy to aid you with completion of this health questionnaire.

Information provided may be stored electronically. All information provided is stored confidentially.

Mission Oaks Medical Centre

All questions contained in this questionnaire are strictly confidential and will become part of your medical record if accepted.

Please complete as many of the sections as you feel comfortable answering. We can aid you with completion of this form

Name: (Last, First, Middle) ☐ M ☐ F	DOB:

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PERSONAL HEALTH HISTORY

Childhood Illnesses: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic ☐ Polio ☐ Other (list below)

Immunization and dates (if known):

☐ Tetanus ☐ Meningococcal C ☐ Pneumonia ☐ Complete childhood immunizations

☐ Hepatitis A ☐ Hepatitis B ☐ Chickenpox ☐ Typhoid

☐ Influenza ☐ HPV (wart virus) ☐ MMR (Mumps, Measles, Rubella)

List any medical problems, diagnoses, surgeries, and admissions to hospital (with reason for admission):

List your prescribed drugs and over-the-counter drugs. Please include supplements, vitamins, and herbal remedies.

Name of drug	Strength	Frequency Taken

ALLERGIES TO MEDICATION

Name of the drug:	Reaction you had:

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS IN THIS SECTION ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise	☐ Sedentary (No Exercise)		
	☐ Mild Exercise (i.e. climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (i.e. work or rereation 4x/week for 30 min.)		
Diet	Are you dieting?	☐ YES	☐ NO
	If yes, are you on a physician prescribed medical diet?	☐ YES	☐ NO
	# of meals you eat in an average day?		
	Rank salt intake ☐ High ☐ Med ☐ Low		
	Rank fat intake ☐ High ☐ Med ☐ Low		
Caffeine	☐ Coffee ☐ Tea ☐ Cola ☐ None		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?	☐ YES	☐ NO
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	☐ YES	☐ NO
	Have you considererd stopping?	☐ YES	☐ NO
	Have you ever experienced blackouts?	☐ YES	☐ NO
	Are you prone to "binge"drinking?	☐ YES	☐ NO
	Do you drive after drinking?	☐ YES	☐ NO
Tobacco	Do you use tobacco?	☐ YES	☐ NO
	Cigerette Packages per day Chew # day: Pipe # Day:		
	Number of Years Year Quit: Cigars # day:		
Drugs	Do you currently use recreational or street drugs?	☐ YES	☐ NO
	Have you ever given yourself street drugs with a needle?	☐ YES	☐ NO
Sex Optional Section	Are you sexually active?	☐ YES	☐ NO
	If yes, are you trying for a pregnancy?	☐ YES	☐ NO
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of the illness?	☐ YES	☐ NO
Personal Safety	Do you live alone?	☐ YES	☐ NO
	Do you have frequent falls?	☐ YES	☐ NO
	Do you have vision or hearing loss?	☐ YES	☐ NO
	Do you have an Advance Directive or Living Will?	☐ YES	☐ NO
	Would you like information on the preparation of these?	☐ YES	☐ NO
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ YES	☐ NO

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS	CHILDREN		Age	Significant Health Issues
Father			☐ M ☐	F		
Mother			☐ M ☐	F		
Siblings			☐ M ☐	F		
☐ M	☐ F		☐ M ☐	F		
☐ M	☐ F		Grandmother *Maternal*			
☐ M	☐ F		Grandfather *Maternal*			
☐ M	☐ F		Grandmother *Paternal*			
☐ M	☐ F		Grandfather *Paternal*			

MENTAL HEALTH

Is stress a major problem for you?	☐ YES ☐ NO
Do you feel depressed?	☐ YES ☐ NO
Do you panic when stressed?	☐ YES ☐ NO
Do you have problems with eating or your appetite?	☐ YES ☐ NO
Do you cry frequently?	☐ YES ☐ NO
Have you ever attempted suicide?	☐ YES ☐ NO
Have you ever seriously thought about hurting yourself?	☐ YES ☐ NO
Do you have trouble sleeping?	☐ YES ☐ NO
Have you ever been to a counselor?	☐ YES ☐ NO

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in (describe below)
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Any other information