Morningstar
Family Medicine

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Welcome!

In order for your new family physician to provide the best care for you, it would be helpful for them to know a bit more about your previous health, your lifestyle, and your current medical concerns. If you are on our wait list, please complete the following questionnaire and drop it off at the office as soon as possible. Your physician can review your responses in advance and therefore make the most of your first visit.

Please be advised that your initial appointment will likely be dedicated to reviewing the information below and ensuring your prescriptions, bloodwork, and other testing is up to date. You and your physician can then make a plan going forward to address any new medical concerns at future appointments.

Attention: Completed intake forms will only be accepted for patients that have already called the office and have been placed on the wait list. Forms must be faxed or dropped off directly to Morningstar Family Medicine during our hours of operation (Mon-Thursday 0900-1200/1300-1600. Forms left at the neighbouring pharmacy will not be accepted. Due to the volume of new patients, it might take several months for an initial appointment.

Demographic information

Full name _____

Birthdate _____

Age _____

Sex _____

Current address _____

_____

Phone Number _____

Health card number _____

Ethnicity _____

Languages spoken _____

Social information

Marital status single / married / common-law / divorced / widowed

Name of partner,
if applicable

With whom do you live?

What are the names of your children, if any?

What is your highest level of education? (eg. High school, Master's degree, etc.)

Please list your occupation (current, and previous)

Do you have private insurance for physiotherapy, massage, etc.? Yes No

If you wish to disclose, do you have insurance through aboriginal status? Yes No

Who is your Power of Attorney for Personal Care?

Who is your Power of Attorney for Finances?

Current medications

Medication name	Dose	Frequency	Why do you take this?
eg. Perindopril	4mg	twice a day	blood pressure

Over the counter medications

Please list any over the counter medications, supplements or herbal remedies that you take.

Allergies

Please list any allergies you have, as well as your reaction.

Previous surgeries

Please list any surgeries, the approximate year, and the surgeon if you remember.

Previous mental health concerns

Please list any current or previous concerns about your mental health and any treatments (therapy, medication, etc.).

Previous medical issues

Please list any medical conditions for which you have seen a doctor. If you needed treatments like medications or surgery, please list that.
If you are currently seeing a specialist for a medical issue, please list that as well.

Lifestyle information

Have you ever smoked? Yes No

If yes, for how many years did you smoke? How many packs per day? When did you quit?

How many alcoholic drinks do you have in a typical week?

Do you use cannabis for medical / recreational purposes?

Do you, or have you ever, used other recreational drugs?

Have you ever struggled to control the amount of alcohol, marijuana or drugs you use?

Do you exercise? How many times per week? How long per session?

Home services and supports

Do you currently receive any services at home such as Meals on Wheels, home nursing, personal support workers, etc.? Please list:

_____

_____

_____

_____

Do you use a gait aid, such as a walker, cane, or wheelchair? _____

Do you currently drive? _____

Preventative health review

Please indicate, as best you remember, when you last had the following tests.
Please write down if they were ever abnormal.

Pap smear _____

STI testing _____

Mammogram _____

Colonoscopy _____

Stool testing for colon cancer _____

Bone density (osteoporosis) _____

Tetanus vaccine _____

Pneumonia vaccine _____

Shingles vaccine _____

Routine bloodwork _____

Family history

Condition	Family member (eg. Mother)	Age at diagnosis
Diabetes		
High blood pressure		
Heart attack		
Stroke		
Other heart disease		
Breast cancer		
Colon cancer		
Ovarian cancer		
Uterine cancer		
Other cancer (specify)		
Osteoporosis		
Broken hip		
Dementia /		
Mental health		
Addiction		