For Office Use Only:
Date Received: _____
Appointment Date: _____
Confirmed: yes (circle)

Dr. Kate Coulson: Patient Intake form

Name: _____ DOB (dd/mm/yy): _____

Health Card Number: _____

Address: _____

_____

Best Phone: _____ Secondary Phone:_____

Previous Family Physician (GP): _____ Location: _____

Approximate date of last visit to your GP: _____

Please list all specialists that you currently see or have seen in the past:
(Attach separate page if needed)

Name	Specialty	Most Recent Visit

Please list any recent hospitalizations (not for surgery)

Diagnosis	Hospital	Date (approximate)

Current Medical Issues:

_____

_____

_____

Past Medical Issues:

_____

_____

_____

Past Surgeries: (attach extra page if needed)

Type of Surgery	Hospital	Date (approximate)

Your Pharmacy Name: _____

Prescription Medications: i.e. Metoprolol 25mg twice a day
(Attach extra page if needed, or provide pharmacy printout if available)

Drug Name	Dose	Frequency

Over the Counter Medications: (please list any vitamins, herbals, or supplements)

_____

Medication Allergies:

Medication	**Reaction**

Environmental Allergies: _____

HEALTH SCREENING

Bone Mineral Density: Date _____ Result (circle one): Normal/Abnormal

Immunizations: When was your last tetanus (TD) booster? _____
Is your childhood immunization record up to date? (circle) YES NO UNSURE

Colon Cancer Screening:
Colonoscopy: Date _____
Result (circle one): Normal/Abnormal

FOBT: Date _____
Result (circle one): Normal/Abnormal

Women Only:
Pap Smear: Date _____
Result (circle one): Normal/ Abnorm

Mammogram: Date_____
Result (circle one): Normal/Abnormal

Social History:

Martial status (circle): Single Married Common Law Divorced Widowed

Are you currently pregnant? YES NO

Do you have children? YES NO How many? _____

Occupation: _____ Do you have benefits / drug plan? YES NO

Highest level of education completed: _____

Who lives with you at home: _____

Emergency Contact Name: _____ Mobile Number: _____

POA (Power of Attorney – Health): _____

HABITS:

Number of alcohol beverages in an average week: _____

Do you smoke? YES NO I QUIT

- If yes, or quit: Age started smoking:_____ # cigarettes / day: _____
- Number of packs / week: _____ When did you quit: _____

Non-prescription Drugs: _____ Average use / week: _____

Exercise (circle): YES NO How many times / week: _____

How Long per exercise session: _____ What type of activity: _____

Family History: (Please list which family member had the illness and what age they were diagnosed ex. Brother age 65)

1. Colon Cancer: Yes/No _____
2. Breast Cancer: Yes/No _____
3. Diabetes: Yes / No _____
4. Heart Attack: Yes/No _____
5. Stroke: Yes/No _____
6. Other (Please list)_____

If you have children under the age of 16 you would like to enroll with Dr. Coulson, please write their name, health card number, and date of birth on the back of the page. For children over 16 please complete a separate form.

Please bring your child's immunization record to intake appointment.

Signature: _____ Date: _____