Essex County
Nurse Practitioner-Led Clinic

Clinique dirigée par du personnel
infirmier praticien du comté d'Essex

PERSONAL AND MEDICAL DATA FORM (ADULT)

Thank you for your interest in becoming a client at the Essex County Nurse Practitioner Led Clinic. The ECNPLC collects, uses, and discloses personal information in compliance with the guidelines of the Personal Health Information Policy Act (PHIPA). The priority of the ECNPLC is to provide primary health care services to residents who live in Essex and surrounding communities who **do not** have a primary care provider. Please answer the following questions to the best of your knowledge.

Today's Date: _____

Name: _____ **Date of Birth:** _____

Address: _____

Phone number: _____ **Alternate number (cell #)**_____

Health card number: _____ **Version Code:** _____ **Expiry Date:** _____

Emergency Contact: _____ **Relationship:** _____

Previous Primary Care Provider: _____

Specialist/s you are currently seeing or have seen in the past (ENT, Psychiatrist, Cardiologist, etc):
_____

How did you hear about our clinic? _____

How would you rate your health in general?

☐ Excellent ☐ Good ☐ Okay ☐ Below average ☐ Poor

PAST MEDICAL HISTORY:

Please check the boxes below if you have had any of the following:

☐ High blood pressure	☐ Depression	☐ Anxiety
☐ Cardiac Pacemaker	☐ COPD/Emphysema	☐ Stroke
☐ Heart Murmur	☐ Angina	☐ Fainting/Seizures
☐ Heart Attack	☐ Rheumatic Fever	☐ Joint Replacement
☐ Diabetes	☐ Hepatitis/Jaundice	☐ Kidney Disease
☐ High Cholesterol	☐ Tuberculosis	☐ Asthma
☐ Mental illness	☐ Liver Disease	☐ Sexually Transmitted Disease
☐ AIDS/HIV Infection	☐ Thyroid problems	☐ Cancer
☐ OTHERS:		

Have you had any previous hospitalizations, surgeries, illnesses or injuries? ☐Yes ☐No

If yes, please list below with dates/year:
1)

2)

3)

4)

ALLERGIES:

Please list allergies or reactions to medications, vaccines, food, environmental factors (dust, pollen)

Allergy	Reaction

MEDICATIONS:

Are you taking Narcotics/Controlled Substances for pain, sleep, ADHD or any other reason? YES or NO

If so how long have you been on them and what are you taking them for?

Please list current medications, vitamins, supplements (even those used intermittently)

Name	Strength/Dose	Frequency

Pharmacy: _____

Location: _____

IMMUNIZATIONS:

Flu vaccine	Year:	Reaction: Yes/No
Pneumonia vaccine	Year:	Reaction: Yes/No
Tetanus booster	Year:	Reaction: Yes/No
Shingles	Year:	Reaction: Yes/No
Hep A	Year:	Reaction: Yes/No
Hep B	Year:	Reaction: Yes/No
	Year:	Reaction: Yes/No
	Year:	Reaction: Yes/No

SOCIAL HISTORY:

Are you currently ☐ Working ☐ Retired/Stay-at-home ☐Ontario Works/ODSP ☐Student

Highest level of Education attained: _____

Ethnic/Cultural Background: _____ Religious Affiliation: _____

Number of People living at home: _____

Are you ☐ Single ☐Married/Common-Law ☐Separated/Divorced ☐Widow

FAMILY HISTORY: Has any of your blood relatives had any of the following? Please indicate relationship (mother, father, brother, sister, maternal/paternal grandmother, grandfather, etc)

☐ Alcoholism/Drug abuse: _____ ☐ High cholesterol_____

☐ Cancer _____ ☐ High Blood pressure _____

☐ Heart disease _____ ☐ Stroke _____

☐ Mental Health problems _____ ☐Bleeding/clotting disorder _____

☐ Genetic disorder _____ ☐ Diabetes _____

☐ Asthma/COPD _____ ☐ Others _____

LIFESTYLE HABITS:

Do you currently smoke or use tobacco? ☐Yes ☐No

If yes: how much and for how long? _____ cig/day for _____ years

If you have smoked in the past, what year did you quit? _____

Are you interested in quitting? ☐Yes ☐No ☐Not applicable

How often do you exercise? ☐ None ☐1-2 times/week ☐3-4 times/week ☐ Daily

How much alcohol do you drink? ☐ None ☐1-2x/wk ☐3-4x/wk ☐ Daily

Do you use street/recreational drugs? ☐Yes ☐No

Have you used intravenous drugs? ☐Yes ☐No

How much coffee do you drink a day? ☐ None ☐1-2 cups ☐3-4 cups

Have you ever had a blood transfusion? ☐Yes ☐No

Are you Sexually Active ☐Yes ☐No

Are you using a form of contraception? ☐Yes, _____ ☐No

HEALTH MAINTENANCE SCREENING TESTS:

Have you had	No	Yes	If yes, when? Month/Year	Result?
Physical exam				
Eye exam				
Dental exam				
Laboratory test (to check for diabetes, cholesterol, etc)				
BMD (for osteoporosis)				
Colonoscopy or Stool card (Colorectal Cancer)				
Rectal exam or PSA blood test (Males)				
Mammogram (Females)				
Pap/pelvic test (Females)				

PLEASE LIST SPECIFIC HEALTH CONCERNS THAT YOU WOULD LIKE YOUR NURSE PRACTITIONER TO KNOW ABOUT BEFORE YOUR VISIT:

Please be sure to include any information not already reported on this form.

1)

2)

3)