PERSONAL AND MEDICAL DATA FORM (16 YRS AND OLDER)

Thank you for your interest in becoming a client at Essex 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 (As appears on Health card) ______________________________Date of Birth: ____________
YYYY/MM/DD

Mailing Address____________________________City_________________postal code____________

Contact numbers Preferred#__________________________Alternate#_______________________

Health card number____________________________ Version code _______ Exp date __________

Emergency Contact Name _________________ P# ___________________Relationship__________

PHARMACY you use____________________________ Your EMAIL: ____________________________

Do you consent to receiving email communications? This form of communication will not include any personal health information and is strictly one way. You will not be able to email us. ◯Yes ◯ NO

Specialist you are currently seeing or have seen in past (ENT, Psychiatrist, Cardiologist, etc.)

____

Medical History: check off if applies to you

( ) High blood pressure	( ) COPD/ Emphysema/Angina	( ) Depression
( ) Coronary heart disease	( ) Sleep Apnea	( ) Dementia
( ) Heart Attack (MI)	( ) Smoke cigarettes	( ) Seizure Disorder
( ) Atrial fibrillation (A-Fib)	( ) Asthma	( ) Reflux (GERD)
( ) Diabetes	( ) Chronic Kidney disease	( ) Chronic Pain
( ) High Cholesterol	( ) Anxiety	( ) Low back pain
( ) Thyroid problems	( )Osteopenia/ osteoporosis	( ) Fainting (syncope)
( ) Stroke or T.I.A	( ) Osteoarthritis	Circle if applies Hepatitis / TB / HIV

Please list allergies to medications, food, or environmental (dust, pollen, dogs….)

Allergy	Reaction

Please list current medications, vitamins and supplements (even if not used every day) or attach a copy of up- to- date list from your pharmacy.

Name &Dosage	How many times a day

DO YOU HAVE AN EXTENDED DRUG PLAN (E.g. Greenshield, Desjardins, Sunlife)? ◯ Yes ◯ No

SOCIAL HISTORY

Occupation_____________________________ ◯ Full time ◯Part time ◯Unemployed ◯Retired

Highest Education completed ◯ Grade school, ◯ High school ◯College/ University

Country of origin__________________________ Religious Affiliation ____________________________

Status: ◯ Married ◯ Common-Law ◯ Divorced ◯ Single ◯Other _____________________________

Any Children? ◯ Daughter____ ◯Son ______ ◯ Other _________

Total number of People living in home _________

RISK FACTORS:

Tobacco Use

Never______Yes _____ If yes how many Packs/Day________ # of years_____

Cigarettes ____ Pipe ______ Cigar _______ Chew ______

Quit Date: _______________________ /or are you interested in quitting? ◯ Yes ◯ No

Alcohol Use

Do you drink alcohol? ◯ Yes ◯ No

drinks per week_________

Is your alcohol use a concern for you or others? ◯ Yes ◯ No

Drug Use

Have you ever tried drugs? ◯ Yes ◯ No

Do you use any recreational drugs? ◯ Yes ◯ No

Have you ever used needles to inject drugs? ◯ Yes ◯ No

LIFESTYLE

Diet

How do you rate your diet? ◯ Good ◯ Fair ◯ Poor.

Do you eat or drink four servings of dairy or soy or take calcium supplements daily? ◯ Yes ◯ No

Do you eat all four food groups? ◯ Yes ◯ No

How many meals per day? _______ How many snacks per day? ________

Caffeine Intake ◯ None ◯ Coffee, tea, soda _____ cups or cans/day

Are you satisfied with your weight? ◯ Yes ◯ No

Explain (would you like to lose or gain weight)? ____

Exercise

Do you exercise regularly? ◯ Yes ◯ No

What kind of exercise? ____

How long? (minutes) ______________________ How often? ____________________________________

If you do not exercise, what is holding you back? ____

FAMILY HISTORY

Please indicate the current status of your immediate family members by blood. Please also indicate family members (e.g. Parent, sibling, grandparent, aunt uncle, etc.) with any of the following conditions.

◯Alcoholism/ Drug use? Who____

◯ High cholesterol? Who____

◯ High blood pressure? who____

◯Stroke? Who____

◯ Metal health problems? Who and type____

____

◯ Diabetes? Who &type____

◯Genetic disorder? Who & what? ________________ Bleeding /clotting disorder? _________________

◯ Asthma/ COPD? Who & which one____

◯ Cancer ◯ Breast _________________________ ◯ Lung_____________________________

◯ Prostate___________________________________ ◯ Colon ______________________________

◯ Uterine/ Ovarian ____

Have you had any previous hospitalizations, surgeries or injuries? ◯ Yes ◯ No.
If yes what and when?

_______________________________________ ____

_______________________________________ ____

_______________________________________ ____

Sexual Activity

Are you sexually active ◯ Yes ◯ No ◯ Not currently?

Current sex partner(s) ◯ Male ◯ Female

Birth Control Method _______________________________________ ◯ None Needed

Have you ever had any sexually transmitted infections/diseases (STDs) ◯ Yes ◯ No

HEALTH MAINTENANCE SCREENING TESTS

WOMEN

Mammo Date of latest & where _________________________Pap Smear Date of latest____________

Bone density test? Date & where _______________________ Fit (fecal occult blood)date ____________

Are you currently pregnant? ◯ Yes ◯ No Date of last normal menstrual period: _______________

How many pregnancies have you had? _______ Any Miscarriages?_________ Any Abortions?________

How many Births? _____________ Full term ____________ Premature ________________

Describe your menstrual cycle, how many days it lasts______ . Flow - light /heavy /variable.

Date of Menopause/onset of symptoms: _______________________

Urinary Incontinence? ◯ Yes ◯ No Amount/Frequency/Known cause_________________________

MEN

Do you experience any of the following?

Difficulty initializing urine? ◯ Yes ◯ No

Weak urine stream? ◯ Yes ◯ No

Dribbling? ◯ Yes ◯ No

Frequent urination at night? ◯ Yes ◯ No, if yes how many times do you get up________________

When was your last physical? ____

Last blood test Date____

Colonoscopy- date of latest and where done ____

Colon cancer Fit (fecal occult blood) test date____

PSA blood test or rectal exam- date of latest ____

Bone Density test-date of latest and where____

IMMUNIZATIONS: Date of latest

Tetanus___________________________________ Hep A __________________________________

Shingles ___________________________________ Hep B___________________________________

Pneumonia _________________________________ Flu shot _________________________________

Please list any information that is not on this form that you feel we should know.

Or any Health concerns.

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