Arbour Family Medical Centre

281 Stone Road East, Guelph, ON N1G 5J5 519-823-5133

New Patient Information

Please note: Information herein will be shared amongst all Physicians who are accepting patients at this office. The medical information requested below is optional. It will not be used as a screening tool, only to triage your concerns before your first appointment.

At present, we have a limited ability to take on new patients. This status fluctuates from week to week, and we will contact you if we are able to accommodate you/your family. Please do not contact our office regarding this form. Because of the number of forms received, it will not be possible to contact everyone. If you have not been contacted by this office within 3 months, it means we are not accepting new patients and this form will be destroyed in keeping with the Personal Health Information Protection Act.

If you are accepted as a new patient, please contact Service Ontario InfoLine at 1-800-267-8097 as soon as possible to de-roster yourself from your previous physician.

Name:_____ Age:____ Gender: M F
Address:_____ Postal Code_____
Home Tel#:_____ Cel/Business #:_____
OHIP#:_____ Exp date: _____ Date of Birth:_____
Email: _____
To be used for general clinic communication, NOT to book appointments or discuss medical issues

Do you currently have a family physician? Yes___ No___
Previous family doctor_____

Other family members in the same household that need a physician
(patients 16+ must complete a separate form):

Name	Date of Birth	OHIP# and Version Code	Relationship to you

Please list any past, current or ongoing health problems *(including any history of depression, anxiety, substance abuse or any other mental health issues:*

1.
2.
3.
4.
5.
6.
7.

List all past operations, illnesses, hospitalizations and injuries: (include dates)

1.
2.
3.
4.
5.
6.

Current Medications *(including supplements and vitamins)*: (do not fill out if you have printed list)

Medication	Dose	Times per day	Reason for use

Allergies *(Including medication) Please* include severity of allergy by rating Mild (3) , Moderate (2) or Severe (1)

1.	3.
2.	4.

Social History:

Smoker: Yes / No # cigarettes/day
Alcohol Use *(please circle)*: _____ # of drinks per: day week month year

Preventative Health *(if known)*:

Date of last Mammogram:
Date of last Pap smear:
Date of last Colonoscopy:
Date of last FOBT:
Date of last Bone Mineral Density:

Family History

Please list any known history of illness in blood relatives (parents and siblings) with particular attention to high blood pressure, diabetes, cancer (and what kind), heart attack or stroke, liver or kidney disease, depression, anxiety or substance abuse.

Family Member	Medical Condition

☐ Ongoing medical investigation with a specialist: if so, Who: _____

Reason: _____

☐ **Meet and Greet requested?** If yes, Date booked: _____

☐ **I have read and understood the New Patient Guide, Clinic Policies, and Uninsured Services.**

Signature: _____ Date: _____

Doctor Signature: _____