# NEW PATIENT APPLICATION FORM

Thank you for taking the time to fill out this application.

Once the completed form has been submitted and reviewed, our receptionist will contact you to arrange a Meet & Greet appointment. We encourage you to please honestly COMPLETE ALL SECTIONS OF THE APPLICATION. Write NOT APPLICABLE (N/A) if a question does not apply to you.

## General information

Last Name: _____ First Name: _____ Preferred Name:_____

Health Card No: _____Version Code:_____ Expiry Date: _____

Date of Birth (dd/mm/yyyy): _____ Age: _____

Sex (M/F/non-binary): _____ Preferred Pronoun: _____

Home Address:_____
Unit Number Street Address City Postal Code

Preferred Phone #: _____ Alternative Phone #:_____

E-mail Address: _____ (please sign the E-mail Correspondence Consent Form)

Emergency Contact (including name, relationship, phone number):_____

_____

Previous Family Doctor's Name, Phone Number & Fax Number:_____

_____

Reason for Changing Doctor: _____

Preferred Pharmacy Name, Address, Fax Number:_____

_____

Allergies (please include the name(s) of medication/food allergy, type of reaction, and age of onset):

_____

## Medical History

Please list CONFIRMED medical or mental health problems that you have been diagnosed with by a health care professional, if any. WRITE N/A IF YOU DO NOT HAVE ANY CONFIRMED DIAGNOSIS.

| Diagnosis | Year of Diagnosis | Name of Specialist (if any) |
|---|---|---|
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Do you have any NEW problems or health concerns that have not been addressed? WRITE N/A IF NONE._____

_____

## Surgeries & Procedures

Please list any surgeries you have had in the past, including any miscarriages, abortions or cesarean sections. WRITE N/A IF NONE.

| Surgery | Date (mm/yy) | Where was this done |
|---|---|---|
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## Medication List

Please list any CURRENT medications that you are taking, including prescription medications, over-the-counter medications and supplements. WRITE N/A IF NONE. Please be ready to discuss ALL of your medications on your first visit (i.e. have your medication pill bottles ready). If you are on MORE THAN 5 medications, please have your pharmacy fax us a "Medications Check".

| Medication Name | Dosage | Frequency | Year Started |
|---|---|---|---|
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## Preventive Screening

Please note that the following applies to certain age groups and risk factors. WRITE N/A IF NONE.

| Screening test | When was the most recent test (mm/yy) | Result (normal or abnormal) |
|---|---|---|
| Pap Smear | | |
| Stool Test (Fecal Immunochemical Test) | | |
| Mammogram | | |
| Colonoscopy | | |
| Bone Mineral Density | | |

## Immunizations

Please note that some immunizations are given to people of certain age groups and risk factors. Some of these questions may not apply to you. For children up to age 18, please email Immunization Record to info@jumkinsmedical.com BEFORE your appointment.

| Dose number | Yes or No | When? |
|---|---|---|
| Last tetanus shot | | |
| Have you had the HPV vaccine (e.g. Gardasil) | | |
| Do you get the yearly flu shot | | |
| Have you had the pneumonia shot (i.e. Pneumovax, Prevnar)? | | |
| Have you had the shingles shot? | | |

**COVID-19 vaccine:**

| Dose number | Yes or No | When? | Which type (tick one) | | | |
|---|---|---|---|---|---|---|
| | | | Pfizer | Moderna | AstraZeneca | Any other |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |

## Social & Lifestyle History

What is your occupation?_____

What is your ethnic background? _____

What language(s) do you speak? _____ Do you require a translator? ❑ Yes ❑ No

Alcohol: Use Do you drink alcohol? ❑ No ❑ Yes If Yes, How many standard drinks/week:_____

Cigarettes: Do you smoke cigarettes? ❑ No ❑ Yes If Yes, How many cigarettes/day:_____

Onset of Use (Age): _____

Caffeine: On average how many caffeinated beverages do you drink a day?_____

Recreational Drug Use (e.g. Marijuana)? ❑ Yes ❑ No
If yes, please provide name of substance, amount, frequency of use, and onset of use:

_____

Do you have any dietary restrictions? _____

Are you have ODSP, OW, or Trillium Coverage ? ❑ Yes ❑ No If yes, which one?_____

Do you have private drug coverage or benefits? ❑ Yes ❑ No

## Form completed by:

_____
*Patient Name*

_____
*Signature*

_____
*Date Signed*