Big Bay Walk in Clinic & Family Practice
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NEW PATIENT INTAKE FORM *- *please note, filling out this form does not guarantee you will be rostered with the doctor at this time.*

Full Name: Preferred Name: _____

Date of Birth: _____ Health Card # and Version Code: _____

Full Address: _____

Preferred Contact telephone: _____ Alternative: _____

Email: _____ Do you consent to be contacted by email: Y N

Gender you identify with: _____

Previous Family Doctor: _____

Emergency Contact/Next of Kin: _____

Emergency Contact Telephone Number: _____

Marital Status: _____ Name of Spouse (if applicable): _____

Race/Ethnicity: _____

Do you smoke? Please circle one: Never, in the past, currently: _____/day

Alcohol Use: Never, In the past, currently: _____/day or_____/week

Cannabis/CBD: Never, In the past, currently: _____/day or _____/week

Exercise: Type: _____

How many times a week? _____, how many minutes in total a week: _____

Gambling: Never Rarely Often

Highest level of Education: _____

Your Occupation: _____

Family History:

Has a male member of your family **under the age of 55** had a stroke or heart attack?

Has a female member of your family **under the age of 55** had a stroke or heart attack?

Your mother: Living, current age_____, died at age_____, health issues: _____

_____

Your father: Living, current age _____, died at age _____, health issues:_____

_____

Sisters: _____ Brother: _____

- I am adopted and do not know my biological family history

Does any of your close relatives have any of the following conditions (parents, grandparents, siblings, aunts/uncles):

High Blood pressure	Heart disease	Stroke
Thyroid Disease	Asthma	Osteoporosis
Breast Cancer	Parkinsons	Prostate cancer
Ovarian Cancer	Dementia/Alzheimer's	Addictions
Mental Health	IBS	Auto Immune

Your Personal Medical History:

Please check all that apply and add details if possible. Example: dates/hospital/surgeon

- Appendix removed
- Bowel surgery
- Gallbladder surgery
- Hernia repair

- Hemorrhoids
- C-section
- Tubes tied/remove
- Ectopic Pregnancy
- Endometriosis
- Ovary Removed/Ovarian cyst
- Bladder/Kidney or Prostate
- Heart Surgery
- Lung Surgery
- Nose surgery
- Tonsillectomy
- Ear surgery
- Thyroid
- Eyes
- Back/Spine
- Joint Replacement
- Other joint/bone/ligament. (ie fractures, ACL, etc.)
- Cancer

Gastroscopy: date:

Colonoscopy: date:

Medical History: please circle one

Blood Sugar: Diabetes, Borderline Diabetes, Low Blood sugar

Blood Pressure: High Blood pressure, Low Blood Pressure

Heart Issues: Heart attack, heart failure, chest pain/angina, heart valve disease, atrial fibrillation, abnormal rhythm, Other: _____

Lung Problems: Asthma, COPD, emphysema, pneumonia, other: _____

Brain: Stroke, mini stroke/TIA, seizures/epilepsy, migraines, chronic headaches, dementia, other:

_____

Ears: hearing impairment, other: _____

Nose: chronic stuffy/runny nose, seasonal allergies, other: _____

Eyes: vision impairment, glaucoma, macular degeneration, other: _____

Mouth/Throat: Dentures, thyroid, other:_____
Liver/Gallbladder: Hepatitis, Fatty Liver, cirrhosis, gallstones, other: _____

Kidney: impaired function, kidney stones, other: _____

Bladder: bladder infections, urination issues, other: _____

Stomach/bowels: constipation, diverticulosis/itis, colon polyps, IBS, Crohn's/ulcerative colitis, hernias, hemorrhoids, celiac disease, other: _____

Thyroid: underactive "hypo", Overactive "hyper", nodules, grave disease, Hashimoto's, other: _____

Joints: osteoarthritis, gout, rheumatoid arthritis, lupus, other: _____

Sleep: sleep apnea, insomnia, other: _____

Mental Health: anxiety, depression, bipolar, schizophrenia, ADHD, fetal alcohol syndrome, addictions, other: _____

Skin: eczema, acne, psoriasis, rosacea, hives, other: _____

Infections: HIV, chlamydia, genital herpes, HPV, gonorrhea

Sexual orientation: heterosexual, homosexual, bisexual, I prefer not to say

Gender Specific Issues:

Female Health:

Age periods started: _____ Age of Menopause: _____ Last regular period: _____

Menstrual periods, **please circle:** Regular Irregular Heavy Flow Painful

Current Birth control, please circle: pill, patch, vaginal ring, copper IUD, hormone IUD, Depo, implant, condoms, calendar, tubes tied, partner vasectomy

Pregnancies: Currently pregnant _____weeks

Number of live births_____ Number of still births_____

Ectopic/tubal pregnancy: _____ Number of miscarriages: _____

Number of abortions: _____

Other, please circle: Abnormal Pap test(s), Polycystic Ovaries, Endometriosis, infertility, other:
_____

Male Health, please circle: erectile dysfunction, premature ejaculation, prostatitis, low testosterone, genital problems, enlarged prostate

Transgender health: Hormone therapy, reassignment surgery

Medication History: If possible, please obtain a meds list from your pharmacy if possible.

Please list all medications, vitamins, drops, supplements and inhalers that you take regularly and occasionally.

Vaccinations: please indicate whether you have had each vaccine and when you received it if possible

Flu Shot

Pneumonia Shot

Shingles

Tetanus

Hepatitis A/B

Covid

Did you receive all of the routine childhood vaccines? _____

Other vaccinations: _____

Do you consent to receive text/email notifications? Y N

Do you consent to a family member making appointments, receiving test results or appointment information on your behalf? Y N

If yes, please provide their full name and telephone number:

_____

Are you currently enrolled with another family doctor in Ontario? Y N

If yes, please provide their name: _____

Patient signature:_____ Date: _____

Guardian name: _____ Relationship to patient: _____

Guardian Signature: _____ Date: _____