New Patient Medical History and Intake Form

*Welcome to **Mahogany Medical**! We look forward to providing quality medical care for you. In order for us to better serve you, please kindly fill out the information below to the best of your knowledge.*

MAHOGANY
MEDICAL CLINIC

Date *(mm/dd/yyyy)*: _____

DEMOGRAPHIC

First Name *(nickname if applicable)*: _____

Middle name: _____ Last Name: _____

Address: _____ Postal code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: _____ Date of Birth *(mm/dd/yyyy)*: _____

Alberta Health Care Number: _____

Emergency Contact Name: _____

Phone number: _____ Relationship: _____

OTHER INFO

How did you hear about us? _____

Who was your previous family doctor? _____

Will you require your medical records be transferred from another clinic? ☐ YES ☐ NO

Would you like to receive clinic email updates? ☐ YES ☐ NO

Would you be interested in receiving text message appointment reminders? ☐ YES ☐ NO

Email address: _____

SOCIAL HISTORY

Your School / Place of work: _____

Your Grade / Occupation: _____

Marital Status: ☐ Single ☐ Common-Law ☐ Married ☐ Divorced ☐ Widowed

Partners Name: _____

Who lives at home with you? _____

ALLERGIES

Medication Allergy: _____ Reaction: _____

Medication Allergy: _____ Reaction: _____

Non-medication Allergy: _____ Reaction: _____

Do you carry an Epi-Pen? ☐ YES ☐ NO

MEDICATIONS

Prescription medications:

Name	Frequency	Dose	Why do you take it?	How long have you been taking it?

Over the counter medications / supplements / vitamins / herbal remedies:

Name	Frequency	Dose	Why do you take it?	How long have you been taking it?

MEDICAL HISTORY

Past Medical History:

Condition	Year of diagnosis	Do you see a specialist for this	Active or Resolved?

SURGICAL HISTORY

Past Surgical History (please include wisdom teeth, LEEP, colonoscopy, eye surgery if applicable):

Date of surgery	Type of surgery	Reason for surgery

PRENATAL HISTORY

No. of pregnancies: _____ No. of deliveries: _____

No. of miscarriages: _____ No. of terminations: _____

When was your last PAP test _____

Date	Hospital	Type of delivery	No. of weeks	Complications	Child's name

LIFESTYLE

Do you smoke? ☐ YES ☐ NO Cigarettes per day: _____

Years of tobacco use: _____

Do you drink alcohol? ☐ YES ☐ NO Drinks per week: _____

Are you concerned about your alcohol use? ☐ YES ☐ NO

If you answered *YES* above please explain why: _____

_____

_____

Have you / do you use any recreational drugs? ☐ YES ☐ NO

☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Heroin ☐ Other

FAMILY HISTORY

Is there any genetic / hereditary diseases known in your family? ☐ YES ☐ NO

Ie. High blood pressure, colon cancer, breast cancer, prostate cancer...

Relationship	Condition	Age of diagnosis	Living or Deceased

#670 | 7 Mahogany Plaza SE | Calgary AB | T3M 2P8
T: 587-355-3300 F: 587-355-3301 E: myhealth@mahoganymedicalclinic.ca