NEW PATIENT FORM

PATIENT NAME (AS IT APPEARS ON BC SERVICES CARD/HEALTH CARD):			
HEALTH CARD NUMBER:			
PATIENT PREFERRED NAME:			
MAILING ADDRESS:			
HOME PHONE:	CELL PHONE:		
DO YOU CONSENT TO TEXT MESSAGES?	YES ☐	NO ☐	
DO YOU HAVE ACCESS TO THE INTERNET?	YES ☐	NO ☐	
EMAIL ADDRESS:			
WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?			
BIRTHDATE: DD/MM/YEAR			
Gender:	Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____		
DO YOU IDENTIFY AS INDIGENOUS? *We are asking because we have resources and additional support available for indigenous patients.*	YES ☐	NO ☐	PREFER NOT TO DISCLOSE ☐
FIRST NATIONS STATUS ☐ FIRST NATIONS NON-STATUS ☐	MÉTIS ☐	INUIT ☐	OTHER ☐ _____
DO YOU EVER FIND IT DIFFICULT MAKING ENDS MEET AT THE END OF THE MONTH?	YES ☐	NO ☐	PREFER NOT TO DISCLOSE ☐
HAVE YOU EVER BEEN VIOLENT? *We are asking because patient and team member safety are top priority. This info is confidential and will not be shared outside your circle of care.*	YES ☐	NO ☐	PREFER NOT TO DISCLOSE ☐
NAME OF PHARMACY:	LOCATION OF PHARMACY:		
LIST NAMES OF YOUR COMPLEMENTARY HEALTHCARE TEAM CARE TEAM OUTSIDE CHC	NAME: PROFESSION:		
	NAME: PROFESSION:		
	NAME: PROFESSION:		
	NAME: PROFESSION:		

MEDICAL HISTORY SUMMARY

Do you have any of the following conditions? (Check all that apply)

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Asthma ☐ Cancer ☐ Stroke ☐ Osteoporosis

☐ Thyroid Problems ☐ Kidney Problems ☐ Arthritis ☐ Epilepsy/Seizures ☐ High Blood Pressure ☐ HIV/AIDS ☐ Other: _____

Are you currently taking any	If yes, list medications:

Medications? ☐ Yes ☐ No	
Do you have any allergies? ☐ Yes ☐ No	If yes, list allergies:
Have you had any surgeries or hospitalizations? ☐ Yes ☐ No	If yes, list procedures and dates:

LIFESTYLE & SOCIAL HISTORY

Do you smoke or use tobacco products? ☐ Yes ☐ No ☐ Former Smoker
How many packs/day? _____ for how many years? _____

Do you consume alcohol? ☐ Yes ☐ No ☐ Occasionally

Do you use recreational drugs? ☐ Yes ☐ No ☐ Occasionally
If so, Inhaling_____ or edibles _____

Occupation:

ARE YOU REGISTERING CHILDREN?		YES ☐	NO ☐	
IF YES, NAME:	BIRTHDATE: DD/MM/YEAR	HEALTH CARD NUMBER:		GENDER:

EMERGENCY CONTACT NAME:	PHONE:
RELATIONSHIP TO YOU:	

DO YOU CONSENT TO SHARE NECESSARY HEALTH INFO WITH THEM, IF REQUIRED?	YES ☐	NO ☐	
Our goal is to provide trauma-informed care in a respectful environment. Please share with your provider anything that might be impactful on your health.			