LOWER COLUMBIA COMMUNITY HEALTH CENTRE

New Patient Form

Welcome to the Lower Columbia Community Health Centre
Please complete this form before your first appointment so we can prepare for your visit

YOUR INFORMATION					
Patient name (as it appears on BC services card/health card):					
Health card number:					
Patient preferred name:					
Birthdate (mm/dd/yyy):					
Gender:					
Preferred pronouns: ☐ he/him ☐ she/her ☐ they/them ☐ other: _____					
CONTACT INFORMATION					
Mailing address:					
Home phone:		Cell phone:			
Do you prefer home phone or cell phone for phone call appointments?					
Email address:					
PHARMACY					
Name of pharmacy:		Location of pharmacy:			
INDIGENOUS IDENTITY					
Do you identify as indigenous?	Yes ☐	No ☐	Prefer not to disclose ☐		
If yes, please indicate:					
First nations status ☐	First nations non-status ☐	Métis ☐	Métis citizenship ☐	Inuit ☐	Other ☐ _____
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 For how many years? _____ how many drinks/week? _____					
Do you use recreational drugs? ☐ yes ☐ no ☐ occasionally					

If so, route of use ☐ edibles ☐ inhaling ☐ nasal ☐ inject

Please list drug and frequency? _____

SOCIAL DETERMINANTS

Please describe your race or ethnicity:

Occupation:

Do you ever find it difficult making ends meet at the end of the month?	Yes ☐	No ☐	Prefer not to disclose ☐

Do you have any spiritual or religious beliefs that you want your care team to know about? Please share:

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:

_____

Have you had any surgeries or hospitalizations? ☐ yes ☐ no	If yes, list procedures and dates:
Are you currently taking any Medications or supplements? ☐ yes ☐ no	If yes, list medications:
Do you have any allergies? ☐ yes ☐ no	If yes, list allergies **and** reaction:

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MENTAL HEALTH		
Do you have any mental health concerns?	Yes ☐	No ☐
If yes, please describe:		

FAMILY MEDICAL HISTORY
Please add any family history (such as cardiac disease, cancer, stroke, inherited conditions)

OTHER HEALTHCARE TEAM
Please list anyone else providing health care services to you (specialists, physio, etc). Name & profession:

CHILDREN			
Are you registering children?		Yes ☐	No ☐
If yes, Name:	Birthdate: Dd/mm/year	Health card number:	Gender:

EMERGENCY CONTACT			
Emergency contact name:	Phone:		
Relationship to you:			
Do you consent to share necessary health info with them, if required?		Yes ☐	No ☐

DIGITAL COMMUNICATION		
Digital communication includes any communication by email, text message or patient portals that are used to communicate with your care team		
Do you consent to digital communication?	Yes ☐	No ☐
Do you want to receive text messages?	Yes ☐	No ☐
Do you want to receive emails?	Yes ☐	No ☐
CLOSING		
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.		