CityMed
Your Partner in Health

4-1493 Foster St White Rock, BC V4B 0C4
Phone: (604) 385-1493

Medical Clinic

NEW PATIENT INTAKE FORM

Patient Information

Last Name : _____ Given Name : _____

PHN : _____ Province : _____

Demographic Information

Gender : _____ Age : _____

Date of Birth : _____

Contact Information

Home Address : _____

Phone # : _____ E-mail : _____

Emergency Contact Name : _____ Phone # : _____

Secondary Phone : _____

Occupation

Occupation : _____ Work Phone : _____

Referral Information

Who referred you to us : _____

Do you consent to receive documents from this clinic via email? : ☐ Yes ☐ No ☐ Other: _____

Family Members

Will other family members join our clinic at the same time?* ☐ Yes ☐ No ☐ Other: _____

*If yes, please ask them to complete a separate intake form for each of them.

Current Family Physician (for possible transfer of records)?

Physician's Name : _____

Clinic Name and Address : _____

Phone and Fax number : _____

Medical History

☐ Make CityMed Pharmacy as Default Pharmacy

Current medical conditions

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

Thank you for completing this form.

4 _____ 9 _____
5 _____ 10 _____

Past medical conditions

1 _____ 6 _____
2 _____ 7 _____
3 _____ 8 _____
4 _____ 9 _____
5 _____ 10 _____

Surgical History
(Please provide details of any surgical procedures that you have undergone or plan to undergo)

1 _____ Place : _____ Year : _____
2 _____ Place : _____ Year : _____
3 _____ Place : _____ Year : _____
4 _____ Place : _____ Year : _____
5 _____ Place : _____ Year : _____

Allergies [Do you have any allergies to medications, food, or other substances? (Please specify or write "None"]

Medications Allergy : _____
Food Allergy : _____

Current Medications

1 Medication Name : _____ Dosage : _____
2 Medication Name : _____ Dosage : _____
3 Medication Name : _____ Dosage : _____
4 Medication Name : _____ Dosage : _____
5 Medication Name : _____ Dosage : _____

Additional Information
[Is there any other relevant information that you would like to add?]

_____
_____

Signature _____
Date _____

Thank you for completing this form.