Please complete and bring with you to your appointment.

Date:______________

Name: ____

Date of Birth: _________________________________ Age:________________

Family Doctor:____________________________

Referring Doctor:_________________________

Marital Status: Married / Common Law / Single / Widowed / Divorced

Occupation (Past or Present):____

Address: ____

Home Phone: ______________________Cell Phone: _____________________

Do you have an answering machine? (please circle one) YES / NO

Alternate Contact Name:____

Alternate Contact Number: ____

Relationship to you: Family / Friend / Other ____________________________

Height: _______cm/ft Weight: _______kg or lb

E-mail:____

I authorize Dr. Justin Clouthier / Dr. Alan Thompson / Dr. Heather Cox permission to access all medical information relevant to my care and treatment.

_____________________________________ ___________________

Patient Signature Date

MAIN PROBLEM (Describe your main symptoms):

____

____

____

Please list all previous surgical procedures/hospital admissions, to the best of your knowledge:

Year	Reason

Please list any other illnesses you have:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

DO YOU SMOKE? Yes ____ No ____

If you previously smoked but have now quit - when? _______

Have you ever seen a Cardiologist (Heart Doctor)? Yes / No / Unsure

If yes, what is the name of your Cardiologist? ______________________

Did you have any heart tests done? Yes / No / Unsure

If yes, where were the tests done?________________________________

Do you have a Pacemaker? Yes / No

Do you have a history of:	**Yes**	**No**	**Name of specialist if one seen for this condition?**
1. Heart or blood vessel problems?			
2. High Blood pressure?			
3. High Cholesterol?			
4. Diabetes?			
5. Stroke?			
6. Blood clots or phlebitis?			
7. Lung problems?			
8. Kidney problems? Are you on Dialysis?			If so, Please circle which days: M T W T F S S Location:
9. Liver problems?			
10. Change in Bowel Habits?			
11. Weight Loss?			
12. Pain in the abdomen (stomach)?			
13. Previous problems with an Anaesthetic?			

Please list the medications you are presently taking
(or you may attach/bring a list with you):
*** **Please include Aspirin and any other Over-the-Counter medications**
*** **If you are on insulin, please include the number of units.**

Name of drug	Dosage	How many times a day?

Pharmacy Name:____

Location:____

ALLERGIES

What Drugs are you allergic to?	Describe the reaction