PATIENT INTAKE FORM - Dr. Michael Ashenhurst & Dr. Vivian Hill

933 17th Avenue SW, Calgary, AB, T2T 5R6 (Suite 344)

P: 403-245-3171, F: 403-245-4205

______________________ / ______________________ / ______________________ / ______________________

LAST NAME (as per health card) FIRST NAME MIDDLE NAME NICKNAME

______________________ / ______________________ / ______________________ / ______________________

STREET ADDRESS CITY PROVINCE POSTAL CODE

______________________ / ______________________ / ______________________

TELEPHONE CELL NUMBER E-MAIL ADDRESS

______________________ / ______ / ______ / ______ M / F ______________________

PERSONAL HEALTH NUMBER DATE OF BIRTH GENDER OCCUPATION

______________________ / ______________________ / ______________________

FAMILY DOCTOR CLINIC NAME CITY

______________________ / ______________________ / ______________________

EMERGENCY CONTACT MOBILE/CELL NUMBER RELATIONSHIP

______________________ / ______________________

NAME OF PARENT / GAURDIAN OF MINOR SIGNATURE OF PARENT / GAURDIAN

*****PLEASE HAVE YOUR MEDICATION LIST READY FOR THE TECHNICIAN*****

______________________ ______________________

PATIENT SIGNATURE DATE

PLEASE READ THE FOLLOWING CLINIC POLICY CAREFULLY:

I FULLY UNDERSTAND THAT ONCE I HAVE CONFIRMED ATTENDANCE TO AN APPOINTMENT AND FAIL TO ATTEND WITHOUT GIVING AT LEAST A 48-HOUR PRIOR NOTICE, A RE-SCHEDULING FEE OF $75.00 WILL HAVE TO BE SETTLED BEFORE I CAN REBOOK THE APPOINTMENT I MISSED.

______________________ ______________________

PATIENT SIGNATURE DATE

Pediatric Questionnaire -Dr. Michael Ashenhurst & Dr. Vivian Hill

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Parents' Names________________________________, ____

Weight at birth ________________ *(Circle Yes or No)*

Was the child premature? **Yes** **No**

If yes, how many weeks premature? ___________

Any complications with the delivery? **Yes** **No**

Any difficulty with feeding or eating initially? **Yes** **No**

Any early developmental delays? **Yes** **No**

Any difficulties in school? **Yes** **No**

Any hereditary/genetic diseases? **Yes** **No**

____

____

Has your child had surgery? **Yes** **No**

If yes, please list:

____ when ____________________

____ when ____________________

____ when ____________________

Have they had any complications with anesthetic? **Yes** **No**

____

Have any family members had complications with anesthetic? **Yes** **No**

____

Does he/she have any allergies or sensitivities to medications? **Yes** **No**

____

Is he/she currently taking any medications? **Yes** **No**

Name ______________________________ Dose_____________ Frequency______________

Name ______________________________ Dose_____________ Frequency______________

Name ______________________________ Dose_____________ Frequency______________

Does he/she suffer from any type of medical condition? Such as Asthma, bleeding problems, seizures, heart murmur?

Yes **No**

____

________________________________ ________________________

Signature of parent/guardian Date

Patient Medical History Form

Patient Name: ____________________ Date: ____________________

YES NO

☐ ☐ 1 Have you had surgeries before (not just eye surgery)? Please list in the table below.
Types of anesthesia eg: General, Regional, Local, IV Sedation

Year	Operation	Type of anesthesic	Hospital

☐ ☐ 2 Have you ever had any complications from anaesthetic?
STATE: ____________________

☐ ☐ 3 Have any members of your family ever had any complications from an anaesthetic?
STATE REACTION: ____________________

☐ ☐ 4 Do you have any known allergies?
Please list and state reaction: ____________________
____

☐ ☐ 5 Do you take any medications, Vitamins, or Aspirin?
If you have a separate list, please give it to our staff
Please list: ____________________
____
____

☐ ☐ 6 Have you ever been on steroids (e.g., Prednisone, Cortisone)?
If so, when? ____________________

7 Have you ever had:

- ☐ ☐ Rheumatic Fever
- ☐ ☐ Heart Attack (when?) ____________________
- ☐ ☐ Angina (chest pain)
- ☐ ☐ High Blood Pressure
- ☐ ☐ Heart Murmur
- ☐ ☐ Other (specify) ____________________

8 Have you ever had:

- ☐ ☐ Asthma
- ☐ ☐ Chronic Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Tuberculosis
- ☐ ☐ Sleep Apnea
- ☐ ☐ Other____________________

QUESTIONS CONTINUE ON BACK

YES	NO	
☐	☐	9 Do you smoke?(Cigarettes, other Tobacco products, or Marijuana)

If so, how much per day, how long? ______________________________

☐	☐	**IF NO**: Have you ever smoked?

When did you quit? ______________________________

10 Have you ever suffered from any of the following (if yes, state when)

YES	NO	Condition	When
☐	☐	Liver Disease, Hepatitis, Jaundice	____________
☐	☐	Diabetes	____________
☐	☐	Kidney Disease	____________
☐	☐	Thyroid Disease	____________
☐	☐	Seizures, or Blackouts, or Stroke	____________
☐	☐	Glaucoma	____________
☐	☐	Heartburn	____________
☐	☐	Arthritis	____________

11 Teeth:

YES	NO	
☐	☐	Any Loose teeth?
☐	☐	Capped teeth (crowns)?
☐	☐	Dentures?
☐	☐	Bridgework?

YES	NO	
☐	☐	12 Any history of alcohol or drug abuse?

(Specify) ______________________________

YES	NO	
☐	☐	13 Can you walk one mile?
☐	☐	Can you go up three flights of stairs?
☐	☐	14 Have you had an electrocardiogram within the last six months? (ECG)
☐	☐	15 Have you had a chest x-ray within the last year?
☐	☐	16 Is there any chance you may be pregnant now?

17 What is your weight? ____________ Kg or ____________ lbs.
What is your height? ____________ cm or ____________ ft.

Pharmacy Name: ______________________________
Pharmacy Phone: ____________ Fax: ____________

Signature: ____________