Murrayville Family Practice Group

New Patient Instructions regarding your first appointment

- The appointment **MUST** be confirmed **2 business days** prior by calling 604-533-1140 or by email: moa@mfpg.ca.
- Unconfirmed appointments will be cancelled.
- Your appointment may be rescheduled if the New Patient Questionnaire Form is not completed at the time of checking in

Please note the following:

1. Arrive 15 minutes prior to allow us to take your vitals before your appointment.

2. Bring your Care card and list of your current medications.

3. Parking is metered so please have adequate coinage or credit card.

We also recommend that due to current construction at the hospital, please allow additional time for parking.

4. If you no longer need this appointment or need to reschedule, please notify our office as soon as possible.

5. Our office is a scent free zone. We request that you refrain from wearing scented lotions, perfumes or colognes when visiting our clinic.

Should you have additional questions, please don't hesitate to contact our office.

Thank you.

New Patient Questionnaire Murrayville Family Practice

Please complete the following form

Last Name: _____ First: _____
Address:

_____
City_____
Postal Code _____
Home Phone: _____Work: _____
Cell: _____Email: _____

Alternate means of communication: ☐EMAIL AND OR ☐ TEXT
Date of Birth: _____ Age: _____
Occupation: _____ ☐ Full Time ☐ Part Time
Employer Name_____
BC Health Care Card #_____
Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Other
Children: _____ Ages: _____
Pharmacy of choice location and name:

_____
Lab of choice, location and name: _____
Advanced Directive ☐ Yes ☐ No
Previous Family Doctor or Clinic _____
Referred to our clinic by: _____

Alternate Contact Information

Name: _____ Relationship: _____
Home Phone: _____ Work: _____ Cell: _____

Medical History

Have you ever suffered from any of the following health conditions?

Diabetes: ☐ Yes ☐ No Details: _____
Heart Disease: ☐ Yes ☐ No Details: _____
Hypertension/High Blood Pressure:
☐ Yes ☐ No Details: _____
Stroke: ☐ Yes ☐ No Details: _____
Asthma: ☐ Yes ☐ No Details: _____
COPD/or other respiratory history
☐ Yes ☐ No Details: _____
Gallstones: ☐ Yes ☐ No Details: _____
High Cholesterol: ☐ Yes ☐ No Details: _____
Arthritis / Joint pain: ☐ Yes ☐ No Details: _____
Kidney / Urinary: ☐ Yes ☐ No Details: _____
Liver disease: ☐ Yes ☐ No Details: _____
Sleep Problems (Apnea, snoring, insomnia)
☐ Yes ☐ No Details: _____

Stomach ulcer: ☐ Yes ☐ No Details:
_____

Heartburn: ☐ Yes ☐ No Details: _____
Trouble swallowing: ☐ Yes ☐ No Details: _____
Neurological: ☐ Yes ☐ No Details: _____
Anemia: ☐ Yes ☐ No Details: _____
Blood Clots: ☐ Yes ☐ No Details: _____
Thyroid: ☐ Yes ☐ No Details: _____
Cancer ☐ Yes ☐ No Details: _____
Depression/Anxiety / Psychiatric Illness
☐ Yes ☐ No Details: _____

Hospital Admissions in last 6 months ☐ Yes ☐ No Details_____

Hospital Admissions in last 12 months □ Yes ☐ No Details_____

Trips to the Emergency Room in last 6 months
☐ Yes □ No Details _____

Trips to the Emergency Room in last 12 months
☐ Yes ☐ No Details _____

List any current or significant medical problems that have not been listed:
_____
_____

Do you have ANY allergies to Medications or other? ☐ Yes ☐ No
Specify: _____
_____
Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? _____
Do you smoke or use tobacco products? ☐ Yes ☐ No
How many cigarettes per day: _____
Have you ever smoked? ☐ Yes ☐ No If YES when did you quit? _____
Do you have a history of drug or alcohol abuse? ☐ Yes ☐ No Details: _____
_____
Do you use any recreational drugs? □ Yes □ No
If yes indicate how often? _____
Specify types of drugs: _____

Please specify any surgeries you have undergone and dates:

_____
_____
_____

Please list any diagnostic investigations (labs/x-rays/ultrasounds/MRIs) done and dates:_____
_____
_____

Please list any previous screenings:

Pap ☐ Yes ☐ No **Date:** _____ **Mammogram** ☐ Yes ☐ No Date: _____
Bone Density ☐ Yes ☐ No Date: _____

Occult Blood (Stool Specimen screening) ☐ Yes ☐ No Date: _____

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Poor
How would you rate your appetite? ☐ Excellent ☐ Good ☐ Poor
How would you rate your diet? ☐ Excellent ☐ Good ☐ Poor
How would you rate your fitness level? ☐ Excellent ☐ Good ☐ Poor
If you live on your own who do you call for assistance? _____
_____
Are your **Vaccines** up to date? ☐ Yes ☐ No
Do you get an annual flu shot? ☐ Yes ☐ No
Have you had a Pneumonia shot? ☐ Yes ☐ No Date: _____
Have you had a Shingles shot? ☐ Yes ☐ No Date: _____
When was you last Tetanus shot? Date: _____
How do you pay for your medications?
Circle: Pharmacare Yourself Private Insurance
How will you get to appointments? _____
Do you use a mobility aid? (I.E. walker, cane, wheelchair) if so which one circle.

Do you wear hearing aid(s)? ☐ Yes ☐ No
Do you wear glasses? ☐ Yes ☐ No
Do you wear dentures? ☐ Yes ☐ No
Is Home Care involved? ☐ Yes ☐ No

Family Medical History: i.e. Diabetes; Heart Disease; Stroke; Cancer etc.

Mother: ☐ Alive ☐ Deceased Health history: _____

Father: ☐ Alive ☐ Deceased Health history: _____

Adopted: ☐ Yes ☐ No Any family history?

Maternal

Grandfather: ☐ Alive ☐ Deceased Health history: _____

Grandmother: ☐ Alive ☐ Deceased Health history: _____

Paternal:

Grandfather: ☐ Alive ☐ Deceased Health history: _____

Grandmother: ☐ Alive ☐ Deceased Health history: _____

Siblings: Number: _____ pertinent health history

☐ Alive ☐ Deceased Health history_____

☐ Alive ☐ Deceased Health history_____

☐ Alive ☐ Deceased Health history_____

☐ Alive ☐ Deceased Health history_____

Other relatives if they have any health history:

Health history_____

Medication

Please report any medications you are currently taking and for what reason.
Include Herbal Medications and vitamins.
Medication Name:
Reason:

Available upon request is a copy of Murrayville Family Practice Group's Privacy Policy, ask at front desk.
Thank you for taking the time to fill out this form. All information provided here will be kept strictly confidential.