Mitchell Family Doctors

New Patient Intake Form

Patient Information

Patient Name: _____

Date of Birth: _____

Health Card (OHIP) Number: _____

Sex: _____

Gender: _____

Phone Number: _____

Do you consent to messages being left on your voicemail? ☐ Yes ☐ No

Address: _____

Email Address: _____

Do you consent to receiving secure email communication? ☐ Yes ☐ No

Pharmacy: _____

Previous Family Doctor: _____

Years Under Their Care: _____

Reason for Leaving e.g moved or Doctor retired: _____

Occupation: _____

Country of Birth: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Mitchell Family Doctors

Relationship to Patient: _____

Civil Status (Single, Common-law, Married, Separated, Divorced, Widowed): _

_____

Household Family Members (List names and ages):

_____

Medical History

Current Medical Conditions:

_____

_____

_____

_____

_____

_____

Past Medical Conditions:

_____

_____

_____

_____

_____

_____

Mitchell Family Doctors

Surgical History (list surgeries and year performed):

_____

_____

_____

_____

_____

_____

Current Medications (Include prescription, over-the-counter, vitamins/supplements):

_____

_____

_____

_____

_____

_____

Allergies to Medications:

_____

_____

_____

_____

_____

_____

Mitchell Family Doctors

Other Allergies (e.g., food, environmental):

_____

Preventive Screenings

If applicable: Last Breast Cancer screening Check: _____
If applicable: Last Colon Cancer Screening: _____
If applicable: Last Bone Density Test: _____
If applicable: Last Cervical Cancer Screening (if applicable):

_____
If applicable: Last Physical Exam: _____

Social History

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how much? _____ pack(s) per day for _____ years
Do you vape? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____ drinks per week
Do you use cannabis? ☐ Yes ☐ No
Do you use recreational drugs? ☐ Yes ☐ No If yes, please list:

_____

Family History

List any significant medical problems in immediate family members:

Heart Disease: _____
Stroke: _____
Diabetes: _____
Abdominal Aortic Aneurysm:

_____
Hypertension: _____
High Cholesterol: _____

Cancers (Please specify type and relationship):

Skin: _____
Blood: _____
Brain: _____

Mitchell Family Doctors

Liver: _____
Kidney: _____
Lung: _____
Pancreas: _____
Thyroid: _____
Colon: _____
Bowel: _____
Bladder: _____
Bone: _____
Sarcoma: _____
Throat: _____
Esophageal: _____
Uterine: _____
Cervical: _____
Ovarian: _____
Prostate: _____
Testicular / Scrotal: _____
Any other cancer: _____
Mental Health Conditions: _____
MS, ALS, Neurofibromatosis: _____
Alzheimer's / Dementia: _____
Other Hereditary Illnesses: _____

Consent

I understand that completing this form does not establish a patient-physician relationship. I certify that the above information is accurate to the best of my knowledge.

Signature (Patient or Legal Guardian): _____

Date: _____