

Welcome Back

PATIENT & INSURANCE INFORMATION...

Date _____ Patient's Name _____
FIRST NAME LAST NAME

Date of Birth _____ Alberta Health Care Number _____ E-Mail Address _____

Has there been any change in your address or telephone numbers? No Yes, please describe the changes below.

Has there been any change in your insurance information? No Yes, please describe the changes below.

MEDICAL HISTORY...

Are you in good health? Yes No • Height _____ Weight _____

Has there been any change in your medical condition since you last visit? No Yes, please describe the changes below.

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

- | | | | |
|--|--|--|--|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> <input type="checkbox"/> Mental health problems | <input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> <input type="checkbox"/> High blood pressure | <input type="checkbox"/> <input type="checkbox"/> Problems with immune system <i>(possibly from med. / surg.)</i> | <input type="checkbox"/> <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> <input type="checkbox"/> Delay in healing | <input type="checkbox"/> <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> <input type="checkbox"/> Contagious diseases |
| <input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> <input type="checkbox"/> Hay fever / Sinus problems | <input type="checkbox"/> <input type="checkbox"/> Blood disorder | <input type="checkbox"/> <input type="checkbox"/> Infectious mononucleosis |
| <input type="checkbox"/> <input type="checkbox"/> Heart murmur | <input type="checkbox"/> <input type="checkbox"/> Snoring | <input type="checkbox"/> <input type="checkbox"/> Bruise easily | <input type="checkbox"/> <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> <input type="checkbox"/> Chest pain / Angina | <input type="checkbox"/> <input type="checkbox"/> Sleep apnea / CPAP | <input type="checkbox"/> <input type="checkbox"/> Eye disease / Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Arthritis / Joint disease |
| <input type="checkbox"/> <input type="checkbox"/> Heart attack(s) | <input type="checkbox"/> <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> <input type="checkbox"/> Jaundice / Liver disease | <input type="checkbox"/> <input type="checkbox"/> Prosthetic implant |
| <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis / Osteopenia |
| <input type="checkbox"/> <input type="checkbox"/> Heart surgery | <input type="checkbox"/> <input type="checkbox"/> Do you smoke or vape <i>If so, how much a day _____</i> | <input type="checkbox"/> <input type="checkbox"/> Fainting spells | <input type="checkbox"/> <input type="checkbox"/> Osteonecrosis |
| <input type="checkbox"/> <input type="checkbox"/> Damaged heart valves | <input type="checkbox"/> <input type="checkbox"/> Do you use chewing tobacco | <input type="checkbox"/> <input type="checkbox"/> Convulsions / Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> <input type="checkbox"/> Pneumonia / Bronchitis / Chronic cough | <input type="checkbox"/> <input type="checkbox"/> A history of marijuana or other drug use | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> GI troubles / ulcers / IBS / Colitis |
| <input type="checkbox"/> <input type="checkbox"/> Chronic fatigue / Night sweat | <input type="checkbox"/> <input type="checkbox"/> A history of alcohol abuse | <input type="checkbox"/> <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> <input type="checkbox"/> Tumor or growth |
| <input type="checkbox"/> <input type="checkbox"/> Trouble climbing 1-2 flights of stairs | | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Cancer / Radiation / Chemotherapy |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | | <input type="checkbox"/> <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> <input type="checkbox"/> Are you on a diet |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | | <input type="checkbox"/> <input type="checkbox"/> Are you on dialysis | <input type="checkbox"/> <input type="checkbox"/> Contact lenses |

MEDICATION & ALLERGIES...

Are you now taking:

- | | | |
|---|--|---|
| Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Nerve pills | <input type="checkbox"/> <input type="checkbox"/> Pain killers (including aspirin) | <input type="checkbox"/> <input type="checkbox"/> Muscle relaxers |
| <input type="checkbox"/> <input type="checkbox"/> Diet pills | <input type="checkbox"/> <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> <input type="checkbox"/> Insulin |

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

| MEDICATION | DOSAGE | FREQUENCY | MEDICATION | DOSAGE | FREQUENCY |
|------------|--------|-----------|------------|--------|-----------|
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|---|
| Y N |
| <input type="checkbox"/> <input type="checkbox"/> Stimulants |
| <input type="checkbox"/> <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> <input type="checkbox"/> Blood thinners (Coumadin, Aspirin) |
| <input type="checkbox"/> <input type="checkbox"/> Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years? |

Are you allergic to, or had a reaction to:

- | | | | |
|--|---|--|---|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Penicillin | <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> <input type="checkbox"/> Local anesthetic (numbing med) | <input type="checkbox"/> <input type="checkbox"/> Amoxicillin |
| <input type="checkbox"/> <input type="checkbox"/> Sodium pentothal / Valium / other tranq. | <input type="checkbox"/> <input type="checkbox"/> Aspirin | <input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> <input type="checkbox"/> Latex |
| <input type="checkbox"/> <input type="checkbox"/> Soy | <input type="checkbox"/> <input type="checkbox"/> Eggs / Yolk | <input type="checkbox"/> <input type="checkbox"/> Sulfites | <input type="checkbox"/> <input type="checkbox"/> Do you have any known allergies |

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

- 1)** Is there a possibility of pregnancy? Yes No **2)** Expected delivery date: _____
- 3)** Are you nursing? Yes No **4)** Are you taking birth control pills: Yes No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____
Signature of patient (*Parent or Guardian if Minor*)

X _____
Reviewed by

X _____
Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____
Signature of patient (*Parent or Guardian if Minor*)

X _____
Date