Dr. Suzanne Gossier
Dr. Marcel Lavanchy
Dr. Florin Covaser

Dr. Richard Blakemore
Dr. Grace-Marie Lenton

3500 Carrington Rd, Suite 107&108, Westbank, BC V4T 3C1
Tel: 250-452-6742, Fax: 250-452-9328
www.vintageviewmedical.ca
https://vintageview.bookmd.ca/

New Patient Intake Form

Please complete this form to the best of your abilities and comfort level, prior to your first visit. This will create a better frame for discussion at your initial visit and will enable your doctor to get to know you faster.

Surname: _____

Middle Name: _____

First Name: _____

PHN: _____; Province: _____; Postal Code: _____

Current Home Address: _____

Best Current Phone Number: _____; this is Other

Secondary Phone Number: _____; this is Other

E-mail Address: : _____ or None

Where you referred to us? No.

If Yes, by: Family Member: _____

Friend (patient here): _____

Other MD/Hospital/Medical Professional: _____

You were referred to/would like to be seen by Dr. Lenton

Will other family members join our clinic at the same time? No.

Is Yes, please complete/ask them to complete a similar form for each of them.

Before us, you used to be seen by (for possible transfer of records):

Dr. _____; Clinic: _____

City: _____; Province: _____

Have you ever been diagnosed with (choose or type):

1. Eye problems, including glaucoma, cataract, macular degeneration,

other: _____

Specialist's name: _____

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2. Ear, nose or throat problems, including hay fever, sinusitis, otitis, laryngitis,

other_____

Specialist's name: _____

3. Cardiovascular problems, including high blood pressure, myocardial infarction (i.e. heart attack), heart failure, aneurysm, rhythm problems (atrial fibrillation, pacemaker),

other_____

Specialist's name: _____

4. Respiratory problems, including asthma, chronic bronchitis, emphysema,

other_____

Specialist's name: _____

5. Digestive problems, including reflux disease, ulcers, gastritis, colitis, diverticulitis,

other_____

Specialist's name: _____

6. Renal (kidney) problems, including stones, cysts, prostate, bladder control,

other_____

Specialist's name: _____

7. Hematologic (blood) problems, including clots, lymphoma, anemia,

other_____

Specialist's name: _____

8. Endocrine (glandular) problems, including diabetes, thyroid disease,

other_____

Specialist's name: _____

9. Rheumatologic (joint) problems, including osteoarthritis, rheumatoid arthritis, lupus,

other_____

Specialist's name: _____

10. Dermatologic (skin) problems, including psoriasis, eczema, lupus, hives,

other_____

Specialist's name: _____

11. Oncologic (cancer) of any location, including breast, uterus, ovary, skin, prostate,

other_____

Specialist's name: _____

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Have you ever had surgeries? Please list briefly the sites and years (if possible):

1. _____; 2. _____

3. _____; 4. _____

5. _____; 6. _____

Have you ever had problems with general anesthesia? No.

Do you have any allergies to (type medication/substance/food, or None)

- Medications? _____

- Other substances? _____

Please list all the medications you take currently, if possible with dosages:

1. _____; 2. _____

3. _____; 4. _____

5. _____; 6. _____

7. _____; 8. _____

9. _____; 10. _____

11. _____; 12. _____

Please list all the over-the counter supplements you take currently:

1. _____; 2. _____

3. _____; 4. _____

5. _____; 6. _____

Did you ever smoke? No.

If Yes: Since what age? _____.

What would you say your daily average was? _____ packs/day (or _____ cigarettes/day).

If you quit, when did you quit? Year: _____ (or Age: _____).

Do you vape nicotine? No.

Do you smoke marijuana? No. Do you ingest marijuana? No.

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How many drinks do you have in a regular week: _____ (or To be discussed with MD).

Are your parents still alive? No.

How old are they now? Mother: Age _____, or Deceased; Father: Age ____, or Deceased

Are you aware of any medical conditions in your family (if possible with age at diagnosis):

Mother:

Father:

Sister 1:

Sister 2:

Brother 1:

Brother 2:

Other 1:

Other 2:

Other 3:

Other 4:

Is there any other relevant information that you would like to add?

Date Completed: _____

Thank you very much for the completion of this form!

Please e-mail it to generalinquiry@vintageviewmedical.ca, with the subject line "New patient", or bring it with you to your visit.

And don't forget to try our **new online booking system** at: https://vintageview.bookmd.ca/