

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



Dr. Richard Blakemore
Dr. Grace-Marie Lenton
Dr. Larisa-Simona Sava

3500 Carrington Rd, Suite 107&108, Westbank, BC V4T 3C1
Tel: 250-452-6742, Fax: 250-452-9328
generalinquiry@vintageviewmedical.ca
www.vintageviewmedical.ca https://tinyurl.com/VVMBooking

New Patient Intake Form

Surname: _____

First Name: _____ Middle Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Personal Health Number (PHN): _____ Province: _____

Current Home Address: _____ Postal Code: _____

Best Current Phone Number: _____; this is

Secondary Phone Number: _____; this is

E-mail Address: : _____ or _____

Which Doctor would like to be seen by? Dr. _____

Will other family members join our clinic at the same time?

- If YES, please complete/ask them to complete a similar form for each of them.

Where you referred to us?

- If Yes, by whom? _____ Find a Family Doctor

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

Dr. _____ Clinic: _____

City: _____ Province: _____

HEALTH QUESTIONNAIRE: Please complete the following questions to the best of your abilities and comfort level, to enable your Doctor to get to know you faster.

Have you ever been diagnosed with:

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

Specialist's name: _____

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

Specialist's name: _____

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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: _____

12. Mental health problems, including depression, anxiety, psychosis, eating disorder,
other _____

Specialist's name: _____

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Have you ever had surgeries? Please list the operation/body part and years (if possible):

1. _____ ; 2. _____
3. _____ ; 4. _____
5. _____ ; 6. _____

Do you have any allergies to any medication or substances?

None

- Medications? _____
- Other substances? _____
- Have you ever had problems with general anesthesia? _____.

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

None

1. _____ ; 2. _____
3. _____ ; 4. _____
5. _____ ; 6. _____
7. _____ ; 8. _____
9. _____ ; 10. _____
11. _____ ; 12. _____

Please indicate if you have participated in Cancer Screening previously.

Cervical cancer screening (PAP test) - last date: _____

Mammogram or breast ultrasound - last date: _____

Colorectal cancer screening (fecal blood test OR colonoscopy) - last date: _____

Do you currently smoke tobacco?

If NO, did you ever smoke?

Year or age when you started? _____.

Year or age when you quit? _____.

What would you say your daily average is / was? _____ cigarettes/day.

Do you vape nicotine?

Do you smoke marijuana?

Do you ingest marijuana?

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

In a regular week, how often do you exercise: _____ minutes/day, _____ days/week.

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Are your parents still alive?

How old are they now? Mother: Age ____ Deceased; Father: Age ____ 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".

We will then contact you to schedule an introductory meeting with your new Doctor.