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

Dr. Richard Blakemore
Dr. Larisa-Simona Sava

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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 HOME / WORK / CELL / OTHER

Secondary Phone Number: _____; this is HOME / WORK / CELL / OTHER

E-mail Address: : _____ or _____

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

Will other family members join our clinic at the same time? YES / NO

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

Where you referred to us? YES / NO

- 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? YES / NO If NO, did you ever smoke? YES / NO

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? YES / NO

Do you smoke marijuana? YES / NO Do you ingest marijuana? YES / NO

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? YES / NO

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", or bring it with you to your visit.

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