The Crown Isle Clinic /Port Augusta Family Practice Group
Patient Waitlist

Date: _________________

Personal Information:

Full Name (according to care card): ____
Gender: _______________________

Preferred Name: (if different than on your Personal Health Card):
____

Power of Attorney/Substitute decision maker (if in place):
____

DOB: Month: ____________________Day: _________________ Year: ________________

Personal Health Number: _____________________________________
Province issued: ______________

Address (please include postal code): ____
____

Phone #: _________________Cell #: __________________

Email: _______________________

Emergency Contacts:

Name: _____________________ Relationship: ________________ Contact

Name: _____________________ Relationship: ________________ Contact

Return to: In person/email: registercipa@gmail.com

The Crown Isle Clinic Unit 300-444 Lerwick Road, Courtenay, BC V9N

Please fill out the medical questionnaire that follows. Thank you!

The purpose of this questionnaire is to ensure that your medical record is up to date when registering you as a new patient. Please fill in the relevant sections to the best of your ability or leave sections blank if you have a question or prefer not to answer. Strict confidentiality is ensured. When dates are requested, the approximate year is sufficient. This information will not be kept on file unless you become a patient at our practice.

Name: ______________________________ Date of birth: __________________

Where have you most recently received your primary health care?

☐ Doctor; if so, whom and where ____

☐ Nurse practitioner; if so, whom and where ____

☐ Walk-in Clinics

Current specialists involved in your care ____

Your medical condition:

▢Heart attack (angina &/or stents)	☐ Kidney disease	☐ Depression
☐ Heart failure	▢ Hypertension	☐ Anxiety disorder
☐ Atrial Fibrillation	▢ Dementia	☐ Bipolar mood disorder
▢ Diabetes	▢ Sleep Apnea	☐ Schizophrenia
▢ Stroke	☐ Asthma	☐ Cancer/Type:
	☐ COPD	

Your previous operations/colonoscopy (when)/endoscopy:

____

____

Your current medications:

____________________ ____________________ ____________________

Any allergies to medication?

__________________________________ __________________________________

Have you had blood work in the last two years? ☐ Yes ☐ No

Do you, or have you ever smoked tobacco products? ☐ Yes ☐ No

~ Quit date? __________________________________

Family history (have your parents, siblings or children experienced the following); Include approximate ages of condition onset:

☐Heart attack (angina &/or stents)
☐ Heart failure
☐ Atrial Fibrillation
☐ Diabetes
☐ Stroke
☐ Kidney disease
☐ Hypertension
☐ Dementia
☐ Sleep Apnea
☐ Asthma
☐ COPD
☐ Depression
☐ Anxiety disorder
☐ Bipolar mood disorder
☐ Schizophrenia
☐ Cancer Type

Women's health section – leave blank if not relevant or applicable:

Last Pap smear (recommended every 3y between ages 25 and 69) __________________________

Abnormal Pap ☐ Yes; when ______________ ☐ No

Last mammogram (recommended screening from age 50) ______________________

Number of pregnancies: ______________ Miscarriages: ___________

Living children: ______________

Social History:

Relationship Status:

☐ Single

☐ Married

☐ Common law

☐ Separated/divorced

☐ Widowed

Spouse/Partners name, if relevant: ____________________________

Your occupation: _________________________ (or circle: Student / Retired / Disability)

Do you have children? If so, please list names and ages:

____

Email/Text Messaging & Voicemail Consent:

Please check the applicable boxes below

▢ You consent to receive emails and SMS text messages from the clinic, which may include non-sensitive medical information (for example lab requisitions or specialist appointments)

Your email is: __________________________

▢ You give permission for the doctor or clinic staff to leave confidential information on your voicemail. Your preferred phone number is: __________________________

I have read and understood this information,

Name: __________________________

Signature: __________________________

Date: __________________________

Thank you for completing this questionnaire! We will confirm by email or phone message when we have a physician available to assume your care. We ask that you reply within 30 days of receiving notification of a doctor becoming available.

Kind regards, ***The Crown Isle Clinic & Port Augusta Family Practice***