HILLTOP MEDICAL CLINIC

Suite 140 15321 – 16th Avenue, Surrey, B.C. V4A 1R6
Phone: 604-531-5575 Fax: 604-535-0126

Dr. J. Nolte Dr. F. O'Brien Dr. J. G. Scott Dr. R. Balakrishna Dr. E. Baasch Dr. P. Mukheibir
Dr. M. Lebl Dr. B. Tyrell Dr. M. Cooner Dr. A. Lamprecht Dr. J. O'Brien Dr. C. Niemand
Dr. I. Amankwe Dr. A. Benitez-Gomez Dr. A. Bredenkamp

Please fill out all fields to the best of your ability and either bring to your appointment or fax to 604-535-0126

Patient History-Date _____

Family Doctor: _____

Full Name:	Email:
Birthdate:	Personal Health Number:

Current chronic (ongoing) concerns: (eg hypertension, diabetes, high cholesterol, fibromyalgia, arthritis etc)

1.	2.
3.	4.
5.	6.

Allergies/reactions to medications/substances

1.	Type of reaction:
2.	Type of reaction:

Past serious conditions or surgeries: (eg heart attack, stroke, hysterectomy, bypass surgery etc)

1.	Date:	2.	Date:
3.	Date:	4.	Date:
5.	Date:	6.	Date:
7.	Date:	8.	Date:

Current medications: Including vitamins, minerals, herbals and over the counter

1.	Strength:	Dosage:	For:
2.	Strength:	Dosage:	For:
3.	Strength:	Dosage:	For:
4.	Strength:	Dosage:	For:
5.	Strength:	Dosage:	For:
6.	Strength:	Dosage:	For:
7.	Strength:	Dosage:	For:
8.	Strength:	Dosage:	For:
9.	Strength:	Dosage:	For:
10.	Strength:	Dosage:	For:

Family history: conditions/diseases present in first degree relatives:

Father: Age	Deceased/Living	Conditions: 1.	2.	3.
Mother: Age	Deceased/Living	Conditions: 1.	2.	3.
Brother: Age	Deceased/Living	Conditions: 1.	2.	3.
Brother: Age	Deceased/Living	Conditions: 1.	2.	3.
Sister: Age	Deceased/Living	Conditions: 1.	2.	3.
Sister: Age	Deceased/Living	Conditions: 1.	2.	3.

Name: _____

Date of Birth: _____

Personal social history (tick or complete as required)

Married # of Marriages: Common Law Divorced Single Widow/er

Children: # of sons_____ Years of Birth_____

# of daughters_____ Years of Birth_____

Occupation: Present occupation: _____ for how long_____

Past occupations: 1._____how long_____; 2._____how long_____

Habits

Smoking: Yes How long: No Never Quit How long:

Alcohol: Yes No Amount Type Frequency

Other Drugs: Marijuana Cocaine Heroin Amphetamines Other:

Exercise

Type: Frequency: Type: Frequency:

Hobbies:_____