

Please fill out all fields to the best of your ability and bring your completed forms with you to your next Hilltop Medical Clinic appointment.

Full Legal Name (as listed on Drivers License): _____

Preferred First Name : _____

Hilltop Family Doctor: _____

History Form - Date Completed: _____

Email: _____

Birthdate (DD/MM/YYYY): _____

PHN (Care Card) _____

Home Phone: _____

Cell Phone: _____

Address: _____

City: _____

Postal Code: _____

Height: _____ (indicate inches or cm)

Weight: _____ (indicate LBS or KG)

Date of Height & Weight: _____

Do you currently have any open ICBC claims?: Y / N

Do you currently have any open WCB claims?: Y / N

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

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Allergies/reactions to medications/substances:

- 1. _____ Type of reaction: _____
- 2. _____ Type of reaction: _____
- 3. _____ Type of reaction: _____

Past serious conditions / surgeries: (eg. heart attack, stroke, hysterectomy, bypass surgery etc) (attach a separate list for additional items)

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

Current medications: Including vitamins, minerals, herbals and over the counter (attach a separate list for additional items)

- 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: _____
- 11. _____ Strength: _____ Dosage: _____ For: _____
- 12. _____ Strength: _____ Dosage: _____ For: _____

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Full Legal Name (as listed on Drivers License): _____

Preferred First Name : _____ Hilltop Family Doctor: _____

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. _____

Personal social history (circle or complete as required)

Current Marital Status (Circle Current Status Below)

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

Children:

# of sons _____	Years of Birth	1) _____	2) _____	3) _____	4) _____
	Health status	_____	_____	_____	_____
# of daughters _____	Years of Birth	1) _____	2) _____	3) _____	4) _____
	Health status	_____	_____	_____	_____

Children's last name if different than yours: _____

Obstetrics:

of pregnancies: Full Term _____ Miscarriage(s) _____ Abortion(s) _____

Year of pregnancies: Full Term _____ Miscarriage(s) _____ Abortion(s) _____

Occupation:

Present occupation: _____ For how long _____

Past occupations: 1. _____ how long _____ 2. _____ how long _____

Current Habits:

Smoking: Y / N For how long (# years): _____ # per day: _____ # per week: _____ Type _____
(Past Habits) Never Smoked: Y / N Quit (year) _____ Smoked for # of Years: _____

Alcohol: Y / N For how long (# years): _____ # per day: _____ # per week: _____ Type _____
(Past Habits) Never Drank Alcohol: Y / N Quit (year) _____ Smoked for # of Years: _____

Other Drugs: Y / N	Marijuana Y / N	Cocaine Y / N	Heroin Y / N	Amphetamines Y / N
	Frequency: _____	Frequency: _____	Frequency: _____	Frequency: _____

Exercise:

1) Type: _____ Frequency: _____ 3) Type: _____ Frequency: _____

2) Type: _____ Frequency: _____ 4) Type: _____ Frequency: _____

Hobbies: _____