

Please fill out all fields to the best of your ability and email completed form to forms@hilltopmedical.ca OR drop them off to Hilltop Medical Clinic. Once received we will contact your with a new patient appointment date & time.

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: _____

Gender: _____ Postal Code: _____

Height: _____ (indicate inches or cm) Weight: _____ (indicate LBS or KG)

Date of Height & Weight: _____

Current & Past Family Doctors: Please list all in order of most recent (and include the year you last saw each doctor):

1. _____ 3. _____

2. _____ 4. _____

Current & Past Medical Specialists: Please list all in order of most recent (and include the year you last saw each specialist):

1. _____ 3. _____

2. _____ 4. _____

Why are you currently looking for a new Family Doctor: _____

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. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

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: _____ 5. _____ Date: _____

2. _____ Date: _____ 6. _____ Date: _____

3. _____ Date: _____ 7. _____ Date: _____

4. _____ Date: _____ 7. _____ 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: _____

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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 Frequency: _____	Cocaine Y / N Frequency: _____	Heroin Y / N Frequency: _____	Amphetamines Y / N Frequency: _____
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Exercise:

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

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

Hobbies: _____