

## Patient Intake Form (PAGE 1)

Legal Name of Patient [First + Middle + Last, +(Preferred Name)]:

Alberta Healthcare Card Number:

Sex:

<input type="text"/>	<input type="text"/>
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Date of Birth(Day/Month/Year):

Address (Street #, Province, Postal Code):

Phone Number (Home / Cell / Work):

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Email Address (For Healthcare Provider Secure Messaging)

Current Family Physician:

Preferred Pharmacy:

<input type="text"/>	<input type="text"/>
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Emergency Contact #1 – Name:

Emergency Contact #1 – Phone:

<input type="text"/>	<input type="text"/>
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Emergency Contact #2 – Name:

Emergency Contact #2 – Phone:

<input type="text"/>	<input type="text"/>
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List of Medications:

Allergies:

Reason for Today's Visit:

## Patient Intake Form (PAGE 2)

Health Conditions: Please check any conditions you have/have had in the past			
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Other:
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other:
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> COPD	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other:
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other:
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Previously Pregnant	<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Other:
Medical History: (Including Surgeries)			
Date (Day/Month/Year)	Condition/Surgery/Procedure		
Preferred Pharmacy: (Name/Address)			

I have completed the form to the best of my ability.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

### OFFICE USE ONLY: Vital Signs from Initial Visit

Body Temp.	Blood Pressure	Pulse Rate	Height (cm)	Weight (kg)	Respiration Rate

**Notes:**