Coquitlam Medical Clinic
501-2992 Glen Drive, Coquitlam BC V3B 0A3 Tel 604-941-8277

Please take the time to fill out this form as completely as possible.

Date:_____

Name:_____

Birthdate: _____Age: _____

Address: _____

_____

Phone number: _____

Do you currently have a primary care provider (GP or NP): _____

If NO, Prev GP/NP: _____

Reason for discontinuation of care: _____

Name of Specialist(s) that you see:

_____

_____

ALLERGIES List medication(s) you are allergic to and what reaction(s) you have

_____

_____

Any open/ Active ICBC/ WCB claims:

_____

_____

PAST MEDICAL HISTORY / SURGICAL HISTORY

Mental health History: _____

HISTORY OF ANY OF THE BELOW:

- ☐ Heart attack'
- ☐ Stroke
- ☐ COPD
- ☐ Asthma
- ☐ Depression
- ☐ Anxiety
- ☐ ADHD
- ☐ Peripheral vascular disease
- ☐ Fibromyalgia
- ☐ Macular Degeneration
- ☐ Tinnitus
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's / Ulcerative Colitis
- ☐ Cancer:

GYNECOLOGICAL HISTORY (if applicable)

Menopause: Age _____ # of pregnancies _____

# of live births _____

CURRENT MEDICATIONS: List all medications, including over-the-counter and homeopathic/ natural remedies, with dosages and times taken if known.

_____

_____

_____

_____

_____

OTHER FACTORS

Smoking history (frequency and amount): _____

Other substances (frequency and amount):_____

Alcohol intake (frequency and amount):_____

FAMILY HEALTH HISTORY (Examples: Cancers, Heart disease, Diabetes?) (please provide age of diagnosis if known)

_____

_____

_____

_____

_____

_____

_____