NAME: _____ DOB: _____ Female

LIFESTYLE (check all that apply and give details)

PLEASE DO NOT WRITE IN THIS COLUMN

Are you: ☐ Single ☐ Married ☐ Common Law ☐ Divorced ☐ Widowed ☐ Other

Partner's Name: Main contact number: ( )

What is/was your occupation?

Main form of exercise?	How many times/week?	How many minutes/time?

Do you smoke? ☐ Yes ☐ No Did you smoke? ☐ Yes ☐ No When did you quit? ____

On average, how much do you/did you smoke per day? _____ For how many years? ____

Do you drink alcohol? ☐ Yes ☐ No

How many drinks do you have in a typical week? ☐ 0 ☐ 1-6 ☐ 7-14 ☐ >15

Do you use any street drugs ☐ Yes ☐ No If yes, please list:

PERSONAL MEDICAL HISTORY (tick all that apply)

☐ High Blood Pressure	☐ Mental Illness	☐ Atrial Fibrillation
☐ Diabetes	☐ Depression	☐ Stroke
☐ COPD/Emphysema	☐ Anxiety	☐ Thyroid Disease
☐ Asthma	☐ Alcohol/Drug Use	☐ Cancer
☐ Heart Attack	☐ Chronic Kidney Failure	☐ Other

PREVIOUS OPERATIONS/SURGERIES	YEAR AND LOCATION

FAMILY HISTORY (tick all that apply)

☐ High Blood Pressure	☐ Mental Illness	☐ Breast Cancer
☐ Diabetes	☐ Depression	☐ Colon Cancer
☐ Asthma	☐ Alcohol/Drug Abuse	☐ Other Cancers
☐ Heart Disease	☐ Thyroid Disease	☐ Other Significant Conditions
☐ Stroke	☐ Dementia	

LIST ALL MEDICATIONS:

DRUG ALLERGIES: ☐ None What Reaction Did You Have?

VACCINATIONS: (and what is the approximate year given)

Tetanus:	Pneumovax:	Zoster/Shingles:
Hepatitis A:	Yearly Flu:	
Hepatitis B:	Human Papilloma Virus (HPV)	

NAME: _____ DOB:_____ Female

OTHER:		
Previous Family Doctor		
Last Complete Physical		
Ever Had An Abnormal Pap ☐ Yes ☐ No If yes, when? _____	Ever Had A Hysterectomy? ☐ Yes ☐ No If yes, when? _____	
Pregnancy History: # of Pregnancies ____ Miscarriages ____ Abortions ____ Births ____		

Revised May 2019

Foothills Family Medical Centre

Dr. Jill Bishop
Dr. Jacques Branch
Dr. Brian Doran
Dr. Timothy Dowdall
Dr. Noel Grisdale
Dr. Tristan Hembroff
Dr. Eric Jablonski
Dr. Gary Ray
Dr. Amanda Schreiner
Dr. Matthew Schuck
Dr. Brian Siray
Dr. Arne Van Aerde

To enhance your care we require the following information to confirm your health history.

Our Practice is proud to be a teaching practice for the University of Calgary. We are also pleased to have other team members in our organization to assist in your care.

HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____

Which pharmacy do you deal? _____

Full Name: _____

Date of Birth: _____

Mailing Address: _____ **Street Address**: _____
_____ _____
_____ _____

Phone Number: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Cell Number: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Work Number: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Email Address: _____

Health Care Number _____

Emergency Contact:_____ **Relationship:** _____
Emergency Contact Phone #: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

FOOTHILLS FAMILY MEDICAL CENTRE
CANCELLATION POLICY

The physicians and staff of the Foothills Family Medical Centre constantly strive to provide the utmost in patient care; therefore we manage emergency scheduling to accommodate our patient's needs.

Our patients choose a time and date for their appointment in advance. We appreciate that you honour this in a responsible fashion by keeping your appointment and arriving in a timely manner. With reasonable notice we are very happy to reschedule your appointment.

There is a big demand for appointments on short notice, as a result we require 24 hours notice to reschedule an appointment. When patients do not provide adequate notice to cancel an appointment, it is time taken from other patients who may be suffering with an immediate requirement.

If you are unable to provide the proper notice to cancel or reschedule an appointment, a fee will be charged to you. Payment will be required prior to rescheduling another appointment. Failure to adhere to this policy will result in termination of services at the clinic.

We appreciate that most of our loyal patients do not cancel with little notice. We recognize also that on rare occasion family emergencies arise and acknowledge that some situations are unavoidable. These short notice cancellations will be assessed on an individual basis, where no penalty will be charged.

For patient convenience the Foothills Family Medical Centre has implemented a cancellation phone service. If you are unable to attend your scheduled appointment please call the clinic at (403) 933-4368 and select option #3 to leave a message to cancel your appointment.

Thank you for you cooperation and understanding.

_____ _____

Signature Date

FOOTHILLS FAMILY MEDICAL CENTRE

J.M. BISHOP, M.D. C.C.F.P.
J.V. BRANCH, M.D.*, C.C.F.P.
B.J. DORAN, M.D.*, C.C.F.P
T. J. DOWDALL, M.B.*, C.H.B. C.C.F.P
N. W. GRISDALE, M.D.*, C.C.F.P.
T.C. HEMBROFF, M.D*, C.C.F.P
*PROFESSIONAL CORPORATION

E. JABLONSKI, M.C.*, C.C.F.P.
G. J. RAY, M.D.*, C.C.F.P.
A. J. SCHREINER, M.D.*,C.C.F.P.
M.J. SCHUCK, M.D.*, C.C.F.P.
B. L. SIRAY, M.D.*, C.C.F.P
A. VAN AERDE, M.D.*, C.C.F.P.

P. O. BAG 460
114 – 1St. SW
Black Diamond AB T0L 0H0
Phone: (403) 933-4368
Fax: (403) 933-2026
Email: clinic@ffmc.ca

Authorization for Release of Medical Records

_____ has come under my care and I would be grateful if you could
(Patient name)
forward me copies of such relevant records and reports that would be beneficial in the ongoing care

of this patient.

Attending Physician _____ **Date**: _____

I _____ hereby authorize _____
(Patient name) **(Doctor/Clinic releasing)**

Address:_____
Phone #:_____
Fax #: _____

to release a photocopy or fax of my medical records to **The Foothills Family Medical Centre**.

This Authorization for Release of Medical Records is limited to the following:

- ☐ EMR summary
- ☐ Consultant Letters
- ☐ Diagnostic Imaging
- ☐ Operative Reports
- ☐ Any Stress Tests, ECG's
- ☐ Most recent – pap, mammogram, PSA, bone density, FIT, colonoscopy
- ☐ Other _____

PATIENT LABEL HERE

Please do not send the entire chart

I hereby authorize any physician, practitioners, hospital or clinic by whom or where I have been observed or treated for any reason, to give full particulars thereof, including medical history.
I am aware that I will be responsible for any costs associated with this reproduction.

_____ _____
Patient Signature Witness Signature