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 ☐7-24 ☐>24			
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:	Covid #1/#2	
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 Aug 2021

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. Chelsea Pocock
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 Full Name: ____

Which pharmacy do you deal? ___________________________________

Date of Birth: _______________________

Address: **Mailing Address**__________________ _____________________

Street Address____

City:____

Postal Code:____

Phone Number: ____________________________

Cell Number: ____________________________

Email Address: ____________________________

Health Care Number ____________________________

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.

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.
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.
C. POCOCK, M.C.*, C.C.F.P.
G. J. RAY, M.D.*, C.C.F.P..
A. 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

<u>Please do not send the entire chart</u>

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

FOOTHILLS FAMILY MEDICAL CENTRE

PATIENT CONSENT FOR ONLINE COMMUNICATIONS
Information Sheet

The Foothills Family Medical Centre supports the use of electronic and online communication with our patients. E-mail, online messengering, text messengering and/or other online platforms are collectively referred to as "online communications" herein. This form constitutes an agreement between you ("you," "patient") and The Foothills Family Medical Centre ("clinic," "our," "us"). Both the provider and patient may agree to communicate using online communications, but neither party is obligated to do so. Online communications is an additional option for communication, not a replacement of traditional means of contact such as telephone, mail or in person.

If you choose to use online communications with our clinic, signing this consent form provides the clinic with your permission to communicate with us using our online platforms. Signing this consent form is required before any form of online communication can be mediated from our clinic. This consent can be withdrawn at any time by contacting the clinic in person or in writing.

APPROPRIATE USES OF ONLINE COMMUNICATION:
Online communication is a convenient way to exchange information. The information you receive from our clinic via online communications is for general or administrative purposes and should not be perceived as medical advice from a physician. Examples of information you may receive from our clinic, include (but are not limited to):

- Reminding you of your appointments;
- Upcoming programs, health promotion material, educational resources and notices for workshops or clinics (e.g. flu shot clinic)

REPLIES:
You will not be able to reply back to inquiries sent in reply to the account. You are responsible for scheduling any necessary appointments and for following up if you believe an online communication was unanswered or not received. For this reason, if you use online communications to relay any information, including personal health information, to the clinic, you are hereby accepting the inherent risk of this information being compromised. Should you have any additional questions or comments regarding online communications or an online message, please call our clinic at 403-933-4368.

RISKS:

All medical communications inherently carry some degree of risk. While the probability of risks associated with the use of online communications in our secure system is very unlikely, the risks are nonetheless real and should be understood.

These risks include, but are not limited to:

- Messages from your care provider may be seen by others using the Internet. Online communication is easy to forge, may be accidentally forwarded, and may exist indefinitely on the internet.
- Online communication messages may exist as an electronic or paper record within the clinic indefinitely.
- The clinic cannot guarantee that messages generated by online communication will be received, read or responded to within any particular period of time. **DO NOT USE ONLINE COMMUNICATIONS FOR MEDICAL EMERGENCIES AND/OR OTHER TIME-SENSITIVE MATTERS.**

TERMS OF USE:

- I understand that it is my responsibility to monitor email received at the indicated email address(es) and to advise the clinic if any email address changes or should no longer be used by the clinic for online communications with myself. I understand that only the email address specified below will be used by the clinic for communication to me.
- If I am signing on behalf of my minor child, I understand that when he/she turns 18, the child will have the option of signing his/her own consent for ongoing online communication with the clinic.
- I understand that the clinic cannot guarantee the security of email and online messages that I send to or receive from the clinic.
- I agree not to use online communications to relay any emergency or urgent information about myself and understand that the clinic does not guarantee the receipt or review of any online messages that I may send to the clinic.
- I understand and agree that individual care providers may make decisions about my treatment based on information I provide through online communication and that this information may form part of my health record.
- I understand that I may stop using online communications for clinical purposes at any time, at which point I will directly notify the clinic in person or in writing, of my decision to stop using online communication for these purposes. I understand that this consent remains effective unless and until it is withdrawn.
- I understand that individual care providers may stop using online communications for clinical purposes at any time, at which point s/he will inform me about this decision within a reasonable time frame.

FOOTHILLS FAMILY MEDICAL CENTRE

Date:

[Patient Label]

I have read and understand the Online Communications information sheet and I accept and agree to all of its terms and conditions.

____

Signature

This consent form lets us know when we may use online communications with you. If at any time you decide that you no longer want us to communicate to you through online communications, please contact our clinic in person or in writing. Your care provider will do the same.

____

Signature

You are agreeing to have read and fully understand this consent form and everything described herein. You agree that online communications with our clinic will only be used for the approved purposes specified above. You understand the risks associated with the communication of online communications between the physicians and patient, and consent to the conditions outlined herein. You acknowledge that if you are signing on behalf of a child, he/she will be eligible to sign their own consent form when they are 18 years old. You acknowledge that Foothills Family Medical Centre reserves the right to revise these terms at any time. Revised terms will be made available to the patient via online or paper copy. Use of the online communication services after such changes are posted will signify your acceptance of the revised terms.