PATIENT INTAKE FORM - Dr. Michael Ashenhurst & Dr. Vivian Hill
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_______________ / _______________ / _______________ / _______________
LAST NAME (as per health card) FIRST NAME MIDDLE NAME NICKNAME

_______________ / _______________ / _______________ / _______________
STREET ADDRESS CITY PROVINCE POSTAL CODE

_______________ / _______________ / _______________
TELEPHONE CELL NUMBER E-MAIL ADDRESS

_______________ / ______ / ______ / ______ M / F _______________
PERSONAL HEALTH NUMBER DATE OF BIRTH GENDER OCCUPATION

_______________ / _______________ / _______________
FAMILY DOCTOR CLINIC NAME CITY

_______________ / _______________ / _______________
EMERGENCY CONTACT MOBILE/CELL NUMBER RELATIONSHIP

_______________ / _______________
NAME OF PARENT / GAURDIAN OF MINOR SIGNATURE OF PARENT / GAURDIAN

PLEASE HAVE YOUR MEDICATION LIST READY FOR THE TECHNICIAN

_______________ _______________
PATIENT SIGNATURE DATE

PLEASE READ THE FOLLOWING CLINIC POLICY CAREFULLY:

I FULLY UNDERSTAND THAT ONCE I HAVE CONFIRMED ATTENDANCE TO AN APPOINTMENT AND FAIL TO ATTEND WITHOUT GIVING AT LEAST A 48-HOUR PRIOR NOTICE, A RE-SCHEDULING FEE OF $75.00 WILL HAVE TO BE SETTLED BEFORE I CAN REBOOK THE APPOINTMENT I MISSED.

_______________ _______________
PATIENT SIGNATURE DATE

Patient Medical History Form

Patient Name: ____________________________ Date: ____________________________

YES NO

☐ ☐ 1 Have you had surgeries before (not just eye surgery)? Please list in the table below.
Types of anesthesia eg: General, Regional, Local, IV Sedation

Year	Operation	Type of anesthesic	Hospital

☐ ☐ 2 Have you ever had any complications from anaesthetic?
STATE: ____________________________

☐ ☐ 3 Have any members of your family ever had any complications from an anaesthetic?
STATE REACTION: ____________________________

☐ ☐ 4 Do you have any known allergies?
Please list and state reaction: ____________________________

____

☐ ☐ 5 Do you take any medications, Vitamins, or Aspirin?
If you have a separate list, please give it to our staff
Please list: ____________________________

____

____

☐ ☐ 6 Have you ever been on steroids (e.g., Prednisone, Cortisone)?
If so, when? ____________________________

7 Have you ever had:

☐ ☐ Rheumatic Fever
☐ ☐ Heart Attack (when?) ____________________________
☐ ☐ Angina (chest pain)
☐ ☐ High Blood Pressure
☐ ☐ Heart Murmur
☐ ☐ Other (specify) ____________________________

8 Have you ever had:

☐ ☐ Asthma
☐ ☐ Chronic Bronchitis
☐ ☐ Emphysema
☐ ☐ Pneumonia
☐ ☐ Tuberculosis
☐ ☐ Sleep Apnea
☐ ☐ Other____________________________

QUESTIONS CONTINUE ON BACK

YES	NO	
☐	☐	9 Do you smoke?(Cigarettes, other Tobacco products, or Marijuana)
		If so, how much per day, how long? ____________
☐	☐	**IF NO**: Have you ever smoked?
		When did you quit? ____________
		10 Have you ever suffered from any of the following (if yes, state when)
☐	☐	Liver Disease, Hepatitis, Jaundice ____________
☐	☐	Diabetes ____________
☐	☐	Kidney Disease ____________
☐	☐	Thyroid Disease ____________
☐	☐	Seizures, or Blackouts, or Stroke ____________
☐	☐	Glaucoma ____________
☐	☐	Heartburn ____________
☐	☐	Arthritis ____________
☐	☐	11 Teeth: Any Loose teeth?
☐	☐	Capped teeth (crowns)?
☐	☐	Dentures?
☐	☐	Bridgework?
☐	☐	12 Any history of alcohol or drug abuse?
		(Specify) ____________
☐	☐	13 Can you walk one mile?
☐	☐	Can you go up three flights of stairs?
☐	☐	14 Have you had an electrocardiogram within the last six months? (ECG)
☐	☐	15 Have you had a chest x-ray within the last year?
☐	☐	16 Is there any chance you may be pregnant now?

17 What is your weight? ____________ Kg or ____________ lbs.
What is your height? ____________ cm or ____________ ft.

Pharmacy Name: ____________
Pharmacy Phone: ____________ Fax: ____________

Signature: ____________