Feel free to make photocopies of this form and pass it on! (Forms must be dropped off in person)

Dr. Pierre-Marc Legault MD CCFP

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Last Name:	First Name:		Birthdate:
Home Address:			
City:	Province:		Postal Code
Home Phone:	Business:		Cell:
Email Address:			
Health Card Number:	Version Code:	Expiry Date:	Gender:
Name of current/previous family physician:			

How did you hear about our clinic?

___ Family/Friend _____

___ Magazines ___Radio ___ Email ___ Web/Internet

Medical History: (Check ✓all that apply)

___ Heart Disease	___ Anemia	___ Migraines/Headaches
___ High Blood Pressure	___ Blood Transfusions	___ Cancer
___ High Cholesterol	___ Kidney Disease	___ Arthritis
___ Pacemaker	___ Liver Disease	___ Diabetes
___ Fainting Spells	___ Hepatitis	___ Glaucoma
___ Aspirin/Blood Thinners	___ Asthma	___ Psychiatric Disorders
___ Artificial Valve, Joint/Prosthesis	___ Emphysema/COPD	___ HIV/AIDS
___ Thyroid Disease	___ Epilepsy	___ Hay Fever/ Allergies

Other illnesses not listed above: _____

Surgeries: _____

Do you smoke? ___ Yes ___ No Do you drink alcohol? ___ Yes ___ No Amount/week: _____

Sexual Orientation: Heterosexual Homosexual Bisexual other

Medications you are currently taking:

_____

Medication allergies? _____

Family History

___ High Blood Pressure	___ Diabetes	___ Suicide
___ Heart Disease/Stroke	___ Psychiatric Disorder	___ Cancer
___ Arthritis	___ High Cholesterol	Others: _____