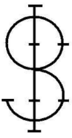
PLEASE COMPLETE ENTIRE FORM



Dr. O.K. Medical Center

PATIENT HISTORY AND PHYSICAL FORM

NAME ______________________ OHIP #______________________ DATE OF APPLICATION __________

ADDRESS(POSTAL CODE) ____

OCCUPATION ______________________

PHONE: Home ____-______-______ Work ______-______-______ Cell ______-______-

CHIEF COMPLAINT ______________________ DATE OF BIRTH ______________

EMERGENCY CONTACT ______________________ PHONE NUMBER ______________

PREVIOUS FAMILY DOCTOR ______________ REASON FOR LEAVING ______________

DRUG ALLERGIES:

CURRENT MEDICATIONS:

FAMILY HISTORY	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

HOSPITILIZATIONS OR SURGERIES

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ____Yes ____No Planning Pregnancy? ____Yes ____No

Age at first period:	LMP:
Sexually Active? YES NO	# of partners:
Sex of partners? M F	Fears of partner/other violence? YES NO

MEDICAL HISTORY

☐ Headache	☐ Pneumonia	☐ Diabetes	☐ Rheumatic Fever
☐ Shortness of Breath	☐ Ulcer	☐ Hepatitis	☐ Glaucoma
☐ Heart Palpitations	☐ GI Disorder	☐ Anemia	☐ Epilepsy/Convulsions
☐ Heart Murmur	☐ Lactose Intolerance	☐ Arthritis	☐ Bleeding Disorder
☐ Chest Pain	☐ Gallbladder Disease	☐ Osteoporosis	☐ Kidney Disease
☐ Dizziness/Fainting	☐ Prostate Disease	☐ Hypertension (High Blood Pressure)	☐ Thyroid Disease
☐ Peripheral Vascular Disease	☐ Bowel Irregularity	☐ Depression	☐ Mental Illness
☐ Allergies/Hay Fever	☐ Incontinence	☐ Gout	☐ Other (please specify)
☐ Asthma/Emphysema	☐ Sexual/Menstrual Dysfunction	☐ Stroke	______________
☐ Bronchitis	☐ Venereal Disease	☐ Cancer	______________

MENTAL HEALTH

Treated for emotional problems?	YES	NO	Date(s):
Considered/attempted suicide?	YES	NO	Date(s):
Neurological/Psychological problems?	YES	NO	

DATE OF LAST

Chest x-ray:	ECG:
Blood Tests:	Eye Exam:
Colon Exam:	TB Test:
Stool for blood:	HIV test:
Mammogram:	Pap:
Prostate Exam:	Other:

Immunization received in the past 10yrs (circle): Tetanus Flu Pneumonia Hepatitis A Hepatitis B Other: ______________.

Childhood Immunizations (circle): Mumps Measles Rubella (German Measles) Polio Pertussis Diphtheria Tetanus

HABITS

☐ **Smoke** ______ packs daily
How long? ______________
When stopped? ____________

☐ **Exercise Routine** ____________
____

☐ **Coffee** ______ cups daily

☐ **Other Caffeine** ______________

☐ **Alcohol:** Type/Amount __________

☐ **Diet:** Salt Intake ______________
Fat Intake ______________

☐ **Sleep**
☐ Difficulty falling asleep
☐ Continuity disturbances
☐ Snoring
☐ Early morning awakening

☐ **Contact with blood or body fluid at work** ______________________________

Do you have a Living Will? ☐ Yes ☐ No