WINDSOR
Family | Health | Team

PATIENT ENROLMENT DATA

All data collected is for the purpose of providing you with patient services. This data will not be shared with any person outside of your circle of care without your consent.

Last Name: _____ First Name: _____ Initial: _____

Preferred Name: _____ Date of Birth: _____

Primary Language: _____ ❒ written ❒ spoken

Secondary Language: _____ ❒ written ❒ spoken

Biological Gender: ❒ Female ❒ Male ❒ Other _____

Additional Optional Details: (If you prefer to verbally disclose this information to your primary care provider please feel free to do so.)

Gender Identity: ❒ Female ❒ Male ❒ Other _____
Sexual Identity: ❒ LGBT ❒ Heterosexual ❒ Other _____

Health Card Number: _____ Version Code: _____ Expiration: _____

Street Address: _____

_____

City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Emergency Contact (name): _____ Relationship: _____

Contact #: _____

Former Family Physician: _____

Pharmacy: _____

Location: _____

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PERSONAL MEDICAL HISTORY: (Please check all that apply (current and past))

CONDITION	CURRENT	PAST (DATE)	DETAILS
Migraines			
Difficulty Breathing			
Sinus Problems			
Dental Problems			
Eye Problems			
High Blood Pressure			
High Cholesterol			
Heart Disease			
Bleeding Problem			
Thyroid Problem			
Diabetes			
Breathing Problem			
Heartburn			
Irritable Bowel Syndrome			
Kidney Problems			
Difficulty Passing Urine			
Chronic Pain			
Muscle Problems			
Arthritis			
Prostate Problems			
Cancer			
Depressions			
Anxiety			
Bipolar Disorder			
Seizures			
Alcoholism/Drug Abuse			
Skin Problem			

Other			

LIFESTYLE:

Do you smoke? ❒ Yes ❒ No If yes, how many per day? _____

Do you drink alcohol? ❒ Yes ❒ No If yes, how many drinks per week? _____

Do you use recreational drugs? (marijuana, cocaine, ecstasy, etc.) ❒ Yes ❒ No

HOSPITAL ADMISSIONS: (Please list the hospital, year and reason for admission)

_____

_____

_____

SURGERIES: (Location, Date, Procedure/Surgery Type)

_____

_____

_____

_____

MEDICATIONS: (If the name is unknown, please list what the medication is for)

1	6
2	7
3	8
4	9
5	10

MEDICATION ALLERGIES: ❒ Yes ❒ No If yes, please fill in below:

1- _____ Reaction: _____
2- _____ Reaction: _____
3- _____ Reaction: _____

ENVIRONMENTAL ALLERGIES: ❒ Yes ❒ No If yes, please fill in below:

1- _____ Reaction: _____
2- _____ Reaction: _____
3- _____ Reaction: _____

FAMILY HISTORY: (Please check all health conditions that your **FAMILY MEMBERS** have)

CONDITION	RELATIONSHIP/DETAILS	YEAR (APPROX.)
Bleeding Problem		
Asthma		
Severe Arthritis		
Alcoholism		
Cancer		
Diabetes		
Seizures		
Glaucoma		
High Blood Pressure		
High Cholesterol		
Heart Attack		
Stroke		
Migraine Headaches		
Osteoporosis		
Skin Disease		
Thyroid Disease		
Genetic Disease		
Depression		
Other Mental Illness		
Other (list)		
Other (list)		