

WE ASK BECAUSE WE CARE

Collecting Your Sociodemographic Information

Windsor Family Health Team
aims to provide the best care possible
to MEET patient's health care needs.

What is Sociodemographic Data?

It is data collected about characteristics of a population such as gender, age, and income for example.
By collecting your sociodemographic data we can reduce health inequities.

Health Quality Ontario states that "health equity allows people to reach their full health potential and receive high quality care that is fair and appropriate to them and their needs, no matter where they live, what they have or who they are".



Collecting Demographic Data Question List

Pronouns

What pronouns do you prefer that we use when talking about you?

Sex

What sex were you assigned at birth?

Gender

What is your sex or current gender?

Occupation

What is your occupation?

Income

What was your approximate total family income before taxes last year?

Number of People Income Supports

How many people does this income support?

Birth Place

What is your country of origin?

Race/Ethnicity

What race category best describes you?

Language

What is your primary and secondary language?



Participation is completely voluntary.



Choosing not to respond will not affect your care or access to our services.

USE OF INFORMATION

What are we going to do with this information?

Windsor Family Health Team plans to study this information to help identify if patient health is impacted by factors including; language, disability, gender, etc. This information will allow your provider to refer you to services and provide information based upon your needs. This information will also be used in service planning and program development.



WINDSOR
Family | Health | Team



UNDERSTANDING INFORMATION COLLECTION

Why is the WFHT collecting patient sociodemographic data?

We collect this information from patients to find out who we serve & what unique needs our patients have. This information allows us to plan for services, and provide even better care. Overall, ensuring that ALL patients have access to the highest quality of care.

Who will see your information?

This information will be accessible only to the health care team taking care of you. If used for research purposes the information will be combined with data from all other patients and no one will be able to identify any specific patient. Example: 45% of WFHT patients identify as male.

How is this relevant to patient care?

The **Ontario Rights Commission** strongly encourages organizations to collect and use sociodemographic information to keep track of outcomes and promote equity. Asking everyone who comes through our doors these questions will encourage patient centred services. We will learn about patients' diverse needs, and tailor accordingly.

All data collected is for the purpose of providing you with the best possible care. If you would prefer to discuss any part of this form in person, please leave that section blank.



PATIENT ENROLMENT DATA

Before completing this enrolment questionnaire please read our [Your Right to Privacy](#) statement that outlines our commitment to privacy, legislative responsibility, collection, uses and disclosures, your choices, safeguards and how to respond to privacy concerns.

Last Name: _____ First Name: _____ Initial: _____

Name you prefer to go by: _____

Date of birth: _____

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

Street Address: _____

City: _____ Postal Code: _____

Primary Phone: _____ Home Mobile/Cell Work Other

Secondary Phone: _____ Home Mobile/Cell Work Other

Emergency Contact (name): _____ Relationship _____

Emergency Contact Phone Number: _____

Patients under 16 years of age are not required to fill the remainder of the form

What pronouns do you prefer that we use when talking about you? (Check all that apply):

- She/her/hers
- He/him/his
- They/them/theirs
- Other: _____

What is your sex or current gender? (Check all that apply)

- Male Female TransMale/Transman
- TransFemale/Transwoman Genderqueer Two-spirit
- Additional Category (Please specify): _____
- Decline to State

What sex were you assigned at birth?

- Male Female Decline to State

This information will not be shared with any person outside of your circle of care without your consent, unless legally required, nor will it be used to determine patient eligibility as WFHT makes every effort to provide care to anyone and everyone.

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Which race category best describes you?

- | | |
|---|---|
| <input type="checkbox"/> Black | <input type="checkbox"/> Latino |
| <input type="checkbox"/> East/Southeast Asian | <input type="checkbox"/> Middle Eastern |
| <input type="checkbox"/> South Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Do not know | <input type="checkbox"/> Indigenous (First Nations, Metis, Inuit) |
| <input type="checkbox"/> Decline to State | <input type="checkbox"/> Another race category: _____ |

What is your country of origin? Canada Other _____
 Date of arrival in Canada: _____

Primary Language: _____ Written Spoken
Secondary Language: _____ Written Spoken

What is your occupation: _____

What was your approximate total family income before taxes last year?

- | | |
|---|--|
| <input type="checkbox"/> \$0 – \$29,999 | <input type="checkbox"/> \$120,000 – \$149,999 |
| <input type="checkbox"/> \$30,000 – \$59,999 | <input type="checkbox"/> \$150,000 or more |
| <input type="checkbox"/> \$60,000 – \$89,999 | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> \$90,000 – \$119,999 | <input type="checkbox"/> Do not know |

How many people does this income support? _____

Former Family Physician:

Preferred Pharmacy Name:

Preferred Pharmacy Address:

Do you wish to enrol for communications from WFHT via email? This will be included an invitation to register for our patient portal where you can book your appointments online.

- Yes No

If Yes, what is your e-mail address: _____

Please take the time to read over the terms and conditions that will be sent to your email address or visit

www.windsorfht.ca/patient-info

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Personal & Family Medical History

This section asks questions about specific medical problems you have now or have had at any time in the past. It also asks about family members with specific conditions. Please check all that apply to you.

Please list your medications:



Please list any previous surgeries including the year they occurred:



Please list any allergies and the associated reaction:



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Have you ever

- | | | |
|---|------------------------------|-----------------------------|
| Been diagnosed with diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Felt like you are thirsty all of the time? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Felt like you need to urinate all of the time? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Known of a family history of diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with gestational diabetes
(diabetes during pregnancy) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with high blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with high cholesterol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Known of a family history of high cholesterol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had a heart attack? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had heart surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had heart stents placed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Experienced chest pain? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Known of a family history of heart attacks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, at what age did the family member have one? _____ | | |
| Had a stroke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had a mini-stroke (Transient ischemic attack - TIA)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with other heart disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with peripheral arterial disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with abdominal aortic aneurysm? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



If you answered yes to any of these questions, please provide brief details:

Have you ever

- | | | |
|---|-----------------------------------|--------------------------------------|
| Been diagnosed with colon, bowel, or rectal cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had colon cancer screening in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, what kind? | <input type="checkbox"/> FOBT/FIT | <input type="checkbox"/> Colonoscopy |
| Had an abnormal FOBT/FIT/Colonoscopy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had colon or rectal surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had rectal bleeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had blood in your stool? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had persistent constipation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Know of a family history of colon or rectal cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with other bowel disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



If you answered yes to any of these questions, please provide brief details:

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Have you ever

- | | | |
|---|------------------------------|-----------------------------|
| Been diagnosed with depression? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with generalized anxiety? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with bipolar disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Known of a family history of bipolar disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with schizophrenia? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Known of a family history of schizophrenia? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Received treatment from a psychiatrist or psychologist? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Received treatment from a therapist? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



If you answered yes to any of these questions, please provide brief details:

Have you ever

- | | | |
|--|------------------------------------|---------------------------------|
| Smoked cigarettes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, how many per day? | <input type="checkbox"/> <1/2 pack | <input type="checkbox"/> 1 pack |
| If yes, when did you start smoking? | _____ | |
| If you used to, when did you quit? | _____ | |
| Used other tobacco or nicotine products? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Persistently coughed up blood? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had persistent night chills or sweats? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with lung cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Known of a family history of lung cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been screened for lung cancer in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, how and when? | _____ | |
| Had lung or chest surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



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This section is intended for biologically female patients. Please skip to the next section if this does not apply to you.

Have you ever

- | | | |
|---|------------------------------|-----------------------------|
| Been diagnosed with breast cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had a mammogram in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, when was your last one? | _____ | |
| Had an abnormal mammogram? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had breast surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had nipple discharge or bleeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Known of a family history of breast cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, at what age were they diagnosed? | _____ | |
| Known of a family history of ovarian cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, at what age were they diagnosed? | _____ | |
| Been told you or family member is BRCA positive | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had chest wall radiation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



If you answered yes to any of these questions, please provide brief details:

Have you ever

- | | | |
|---|------------------------------|-----------------------------|
| Had a pap smear | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, when was your last one? | _____ | |
| Had an abnormal pap smear? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had uterine or vaginal surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had vaginal discharge | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had abnormal vaginal bleeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had vaginal bleeding or spotting after sex? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



If you answered yes to any of these questions, please provide brief details:

This section is intended for biologically male patients. Please skip to the next section if this does not apply to you.

Have you ever

- | | | |
|--|------------------------------|-----------------------------|
| Had difficulty urinating? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Had blood or pus in your urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been diagnosed with prostate cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Know of a family history of prostate cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Been screened for prostate cancer in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had an abnormal PSA result in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, when? | _____ | |



If you answered yes to any of these questions, please provide brief details:

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This section asks sensitive information about your personal life. This information is obtained to provide you with better healthcare. Your entire circle of care at the Windsor FHT will have access to this information unless you specifically request to limit it to a certain individual(s). You can change this information in the future by discussing with your provider. If you would prefer to discuss any of these questions in person, please feel free to leave this section blank.

If you prefer that this personal information remain protected (only accessible by your primary care provider) please check this box otherwise it will be accessible to other team members (example: dietitian, social worker, nurse etc.) if needed.

Do you identify as:

- Asexual Straight (heterosexual) Bisexual
 Gay Lesbian Two-spirit
 An identity not listed (please specify): _____
 Decline to State

Please describe your sexual activity during the last year:

- I did not have any sexual partners
 I was in a monogamous relationship with a man (I had sex with one man only)
 I was in a monogamous relationship with a woman (I had sex with one woman only)
 I had multiple male partners
 I had multiple female partners
 I had both male and female partners

 Decline to State

Please describe your current relationship status (check all that apply):

- Single Married In a civil union
 Divorced Widowed
 In a domestic partnership, living together
 Partnered, not living together
 In a committed relationship

This section asks sensitive information about exercise, daily habits, and routines. If you would prefer to discuss any of these question in person, please feel free to leave this section blank.

- | | | | | |
|---|---|------------------------------------|----------------------------------|--------------------------------|
| How would you rate your diet? | <input type="checkbox"/> Poor | <input type="checkbox"/> OK | <input type="checkbox"/> Healthy | |
| How often do you exercise? | <input type="checkbox"/> Never | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Often | <input type="checkbox"/> Daily |
| Do you drink alcohol? | <input type="checkbox"/> Never | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Often | <input type="checkbox"/> Daily |
| Do you use any other substances or drugs? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| If yes, please check any that apply | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Heroin | |
| | <input type="checkbox"/> Non-prescription narcotics | | | |
| | <input type="checkbox"/> Other(s) _____ | | | |
| When was the last time you had blood work drawn? | _____ | | | |



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Patient Enrolment and Consent to Release Personal Health Information

Please PRINT using black or blue ballpoint pen.

 Collection of the information on this form is under the authority of the *Ministry of Health Act*, subsection 6(1) and (2) and the *Health Insurance Act*, R.S.O. 1990, c. H.6, s.4(2)(b) and (f), 4.1(1) and (2), 10 and 11(1). For information about collection practices, contact the Director, Registration and Claims Branch, Box 48, 49 Place d'Armes, Kingston ON K7L 5J3, INFOline tel. 1 888 218-9929 or by mail through the addresses listed for local Ministry of Health and Long-Term Care offices.

Section 1 – I want to enrol myself with the family doctor identified in Section 4

Last Name		First Name		Second Name	
Health Number	Version Code	Mailing Address ▶	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery	
Date of Birth (yyyy/mm/dd)	Sex <input type="checkbox"/> M <input type="checkbox"/> F		City/Town		Postal Code
Send notices from my family doctor's office to me by: <input type="checkbox"/> regular mail <input type="checkbox"/> email (if possible)		Residence Address ▶ <input type="checkbox"/> or same as mailing address	Apartment #	Street No. and Name or Lot, Concession and Township	
Email Address:			City/Town		Postal Code

Section 2 – I want to enrol my child(ren) under 16 and/or dependent adult(s) with the family doctor identified in Section 4

A Last Name		First Name		Second Name	
Health Number	Version Code	Mailing Address ▶ <input type="checkbox"/> or same as Section 1	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery	
Date of Birth (yyyy/mm/dd)	Sex <input type="checkbox"/> M <input type="checkbox"/> F		City/Town		Postal Code
I am this person's <input type="checkbox"/> parent <input type="checkbox"/> legal guardian <input type="checkbox"/> attorney for personal care		Residence Address ▶ <input type="checkbox"/> or same as Section 1	Apartment #	Street No. and Name or Lot, Concession and Township	
			City/Town		Postal Code

B Last Name		First Name		Second Name	
Health Number	Version Code	Mailing Address ▶ <input type="checkbox"/> or same as Section 1	Apartment #	Street No. and Name or P.O. Box, Rural Route, General Delivery	
Date of Birth (yyyy/mm/dd)	Sex <input type="checkbox"/> M <input type="checkbox"/> F		City/Town		Postal Code
I am this person's <input type="checkbox"/> parent <input type="checkbox"/> legal guardian <input type="checkbox"/> attorney for personal care		Residence Address ▶ <input type="checkbox"/> or same as Section 1	Apartment #	Street No. and Name or Lot, Concession and Township	
			City/Town		Postal Code

Section 3 – Signature

I have read and agree to the Patient Commitment, the Consent to Release Personal Health Information and the Cancellation Conditions on the back of this form. I acknowledge that this Enrolment is not intended to be a legally binding contract and is not intended to give rise to any new legal obligations between my family doctor and me.

I am signing on behalf of (check all that apply)

 myself child(ren) dependent adult(s)

 My Name
last name first name

Signature Date (yyyy/mm/dd)

Home Telephone No. Work Telephone No.

() ()

Section 4 – Family doctor information

PG07799

(Include Billing no. and Group no.)

Family Doctor's Signature Date (yyyy/mm/dd)

X