

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

Do you consent to the use of your Mobile Phone # for SMS Text Message Appointment Reminders? (*We are currently exploring the use of this feature*) Yes No

Emergency Contact (name): _____ Relationship _____

Emergency Contact Phone Number: _____

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

Former Family Physician: _____

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

Do you wish to receive email communications from WFHT and Ocean by CognisantMD?

Ocean is an EMR integrated patient engagement solution that offers Online appointment booking, patient appointment reminders, website forms, eReferrals, etc.

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

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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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 |



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

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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.

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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WINDSOR

Family | Health | Team

Socio-Demographic Form

Full Name: _____
 Date of Birth: _____
 Patient ID: _____

Pre Form Information:

This initiative is driven by the Ministry of Health Ontario

- ▶ The information collected has been proven to influence health outcomes. Collecting this information will allow us to identify who our patients are, keep track of health outcomes, and promote equity within the WindsorFHT.
- ▶ The data that is collected is protected and confidential. It will be stored with your other health care information.
- ▶ Participation is completely voluntary.

If you choose not to answer, your care or access to services will not be affected.

LANGUAGE

What language would you feel most comfortable speaking in with your healthcare provider?

- English French/Francophone
 Arabic Italian
 Another language: _____
 I would like to be connected to Francophone resources in the community

BORN IN CANADA

Were you born in Canada?

- Yes No
 Do not know Prefer not to answer

If NO, how long have you lived in Canada?

- Less than 1 year 4-10 years
 1-3 years 10+ years

RACE/ETHNICITY

Which of the following best describes your racial or ethnic group?

- Asian - East (ex. Chinese, Japanese, Korean)
 Asian - South (ex. Indian, Pakistani, Sri Lankan)
 Asian - South East (ex. Malaysian, Filipino, Vietnamese)
 Black - African (ex. Ghanaian, Kenyan, Somali)
 Black - Caribbean (ex. Barbadian, Jamaican)
 Black - North American (ex. Canadian, American)
 I would like to be connected with community resources that service my group
 First Nations
 I would like to be connected with community resources that service my group
 Indigenous/Aboriginal
 I would like to be connected with community resources that service my group
 Inuit
 I would like to be connected with community resources that service my group
 Metis
 I would like to be connected with community resources that service my group
 Indian - Caribbean (ex. Guyanese with origins in India)
 Oceania
 Latin/Central American (ex. Argentinian, Chilean, Salvadoran)
 Middle Eastern/West Asian (ex. Egyptian, Iranian, Lebanese)
 White - European (ex. English, Italian, Portuguese, Russian)
 White - North American (ex. Canadian American)
 Another Ethnicity: _____
 Unknown
 Prefer not to answer

DISABILITIES

Do you have any of the following disabilities?

- | | | | |
|-----------------------------------------------|---------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Sensory Disability (ex. vision or hearing loss) |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Drug or Alcohol Dependence | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Degenerative Disease | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> None | |
| <input type="checkbox"/> Prefer not to answer | | <input type="checkbox"/> Another Disability: _____ | |

GENDER

How would you describe your gender? (Please check only one)

***Those 12 years old and younger may skip this question.**

- | | |
|------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Woman | <input type="checkbox"/> Gender Fluid |
| <input type="checkbox"/> Man | <input type="checkbox"/> Two-Spirit |
| <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Non-Binary |
| <input type="checkbox"/> Do not know | <input type="checkbox"/> Transgender Man |
| <input type="checkbox"/> Another gender: _____ | <input type="checkbox"/> Transgender Woman |

I would like to be connected with LGBTQ+ resources in the community

PERSONAL PRONOUNS

What are your preferred pronouns? (Please check only one)

- | | |
|------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> She/Her | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> He/Him | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> They/Them | <input type="checkbox"/> Another pronoun not listed (please specify): _____ |

SEXUAL ORIENTATION

What is your sexual orientation? (Please check only one)

***Those 12 years old and younger may skip this question.**

- | | |
|-----------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Two Spirit |
| <input type="checkbox"/> Gay | <input type="checkbox"/> Queer |
| <input type="checkbox"/> Straight | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Do not know |
| <input type="checkbox"/> Asexual | <input type="checkbox"/> Another sexual orientation: _____ |

INCOME

What was your total household income before taxes last year?

If the patient is under 18 years old, this question refers to the house hold income supporting the child

- | | |
|---------------------------------------------|----------------------------------------------|
| <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"/> Do not know |
| <input type="checkbox"/> \$90,000-\$119,999 | |

INCOME

How many people does this income support?

- _____
- Prefer not to answer
- Do not know

INCOME

Do you have difficulty making ends meet with this income?

- | | |
|--------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> No | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Do not know | |

COMMUNITY RESOURCES

Based on the answers I have provided in this form, I would like my provider to connect me with community resources.

- Yes No

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