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.

WINDSOR
Family | Health | Team

PATIENT ENROLMENT DATA

Before completing this enrolment questionnaire, please read our Your Right to Privacy statement thatoutlines our commitment to privacy, legislative responsibility, collection, uses and disclosures, yourchoices, safeguards and how to respond to privacy concerns.

Last Name: _____First Name: _____Initial: ____

Preferred Name:_____

Date of birth:_____ Sex: _____

Street Address: _____

City:_____ Postal Code: _____

Health Card Number: _____ Version Code: _____Expiration: _____

Primary Phone: _____ ☐ Mobile ☐ Home ☐ Other

Secondary Phone: _____ ☐ Mobile ☐ Home ☐ Other

Emergency Contact Name: _____ Phone: _____

Relationship: _____

Former Family Physician: _____

Preferred Pharmacy Name: _____

Do you wish to receive appointment reminders via email?

If yes, please provide your email address: _____

By providing your email address you agree to receive email communications from WFHT and Ocean by CognisantMD? Ocean is the technology we use to securely offer online booking, appointment reminders and other forms of communication. Please read the terms and conditions on our website: 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.

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.

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?	**☐Yes**	**☐No**
Felt like you are thirsty all of the time?	**☐Yes**	**☐No**
Felt like you need to urinate all of the time?	**☐Yes**	**☐No**
Known of a family history of diabetes?	**☐Yes**	**☐No**
Been diagnosed with gestational diabetes (diabetes during pregnancy)	**☐Yes**	**☐No**
Been diagnosed with high blood pressure?	**☐Yes**	**☐No**
Been diagnosed with high cholesterol?	**☐Yes**	**☐No**
Known of a family history of high cholesterol?	**☐Yes**	**☐No**
Had a heart attack?	**☐Yes**	**☐No**
Had heart surgery?	**☐Yes**	**☐No**
Had heart stents placed?	**☐Yes**	**☐No**
Experienced chest pain?	**☐Yes**	**☐No**
Known of a family history of heart attacks?	**☐Yes**	**☐No**
If yes, at what age did the family member have one? _____		
Had a stroke?	**☐Yes**	**☐No**
Had a mini-stroke (Transient ischemic attack - TIA)?	**☐Yes**	**☐No**
Been diagnosed with other heart disease?	**☐Yes**	**☐No**
Been diagnosed with peripheral arterial disease?	**☐Yes**	**☐No**
Been diagnosed with abdominal aortic aneurysm?	**☐Yes**	**☐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?	**☐Yes**	**☐No**	
Had colon cancer screening in the past?	**☐Yes**	**☐No**	
If yes, what kind?	**☐FOBT/FIT**	**☐Colonoscopy**	
Had an abnormal FOBT/FIT/Colonoscopy?	**☐Yes**	**☐No**	
Had colon or rectal surgery?	**☐Yes**	**☐No**	
Had rectal bleeding?	**☐Yes**	**☐No**	
Had blood in your stool?	**☐Yes**	**☐No**	
Had persistent constipation?	**☐Yes**	**☐No**	
Know of a family history of colon or rectal cancer?	**☐Yes**	**☐No**	
Been diagnosed with other bowel disease?	**☐Yes**	**☐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?	**☐Yes**	**☐No**
Been diagnosed with generalized anxiety?	**☐Yes**	**☐No**
Been diagnosed with bipolar disorder?	**☐Yes**	**☐No**
Known of a family history of bipolar disorder?	**☐Yes**	**☐No**
Been diagnosed with schizophrenia?	**☐Yes**	**☐No**
Known of a family history of schizophrenia?	**☐Yes**	**☐No**
Received treatment from a psychiatrist or psychologist?	**☐Yes**	**☐No**
Received treatment from a therapist?	**☐Yes**	**☐No**

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

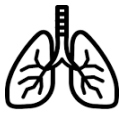
_____

_____

_____

Have you ever

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



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

_____

_____

_____

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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.

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?	**☐Yes**	**☐No**
Had a mammogram in the past?	**☐Yes**	**☐No**
If yes, when was your last one?	_____	
Had an abnormal mammogram?	**☐Yes**	**☐No**
Had breast surgery?	**☐Yes**	**☐No**
Had nipple discharge or bleeding?	**☐Yes**	**☐No**
Known of a family history of breast cancer?	**☐Yes**	**☐No**
If so, at what age were they diagnosed?	_____	
Known of a family history of ovarian cancer?	**☐Yes**	**☐No**
If so, at what age were they diagnosed?	_____	
Been told you or family member is BRCA positive	**☐Yes**	**☐No**
Had chest wall radiation?	**☐Yes**	**☐No**

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

_____

_____

Have you ever

Had a pap smear	**☐Yes**	**☐No**
If yes, when was your last one?	_____	
Had an abnormal pap smear?	**☐Yes**	**☐No**
Had uterine or vaginal surgery?	**☐Yes**	**☐No**
Had vaginal discharge	**☐Yes**	**☐No**
Had abnormal vaginal bleeding?	**☐Yes**	**☐No**
Had vaginal bleeding or spotting after sex?	**☐Yes**	**☐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?	**☐Yes**	**☐No**
Had blood or pus in your urine?	**☐Yes**	**☐No**
Been diagnosed with prostate cancer?	**☐Yes**	**☐No**
Know of a family history of prostate cancer?	**☐Yes**	**☐No**
Been screened for prostate cancer in the past?	**☐Yes**	**☐No**
Have you had an abnormal PSA result in the past?	**☐Yes**	**☐No**
If yes, when?	_____	

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

_____

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.

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.

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?		☐**Poor**	☐**OK**	☐**Healthy**
How often do you exercise?	☐**Never**	☐**Sometimes**	☐**Often**	☐**Daily**
Do you drink alcohol?	☐**Never**	☐**Sometimes**	☐**Often**	☐**Daily**
Do you use any other substances or drugs?			☐**Yes**	☐**No**
If yes, please check any that apply		☐**Marijuana**	☐**Cocaine**	☐**Heroine**
		☐**Non-prescription narcotics**		
		☐**Other(s) _____**		

When was the last time you had blood work drawn? _____

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.

Ontario

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

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?

- ☐ Chronic Pain
- ☐ Chronic Illness
- ☐ Degenerative Disease
- ☐ Developmental Disability
- ☐ Learning Disability
- ☐ Mental Illness
- ☐ Physical Disability
- ☐ Drug or Alcohol Dependence
- ☐ None
- ☐ Sensory Disability (ex. vision or hearing loss)
- ☐ Do not know
- ☐ Prefer not to answer
- ☐ Another Disability: _____

GENDER

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

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

- ☐ Woman
- ☐ Man
- ☐ Prefer not to answer
- ☐ Do not know
- ☐ Another gender: _____
- ☐ Gender Fluid
- ☐ Two-Spirit
- ☐ Non-Binary
- ☐ Transgender Man
- ☐ 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)

- ☐ She/Her
- ☐ He/Him
- ☐ They/Them
- ☐ Prefer not to answer
- ☐ Do not know
- ☐ 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.**

- ☐ Bisexual
- ☐ Gay
- ☐ Straight
- ☐ Lesbian
- ☐ Asexual
- ☐ Two Spirit
- ☐ Queer
- ☐ Prefer not to answer
- ☐ Do not know
- ☐ 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

- ☐ $0-$29,999
- ☐ $30,000-$59,999
- ☐ $60,000-$89,999
- ☐ $90,000-$119,999
- ☐ $120,000-$149,999
- ☐ $150,000 or more
- ☐ Do not know

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?

- ☐ Yes
- ☐ No
- ☐ Do not know
- ☐ Sometimes
- ☐ Prefer not to answer

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

Ontario

Ministry of Health
and Long-Term Care

Microfilm use only

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 (l), 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

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Send notices from my family doctor's office to me by:
☐ regular mail ☐ email *(if possible)*

Email Address:

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as mailing address

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

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as Section 1

B

Last Name | First Name | Second Name

Health Number | Version Code

Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

I am this person's
☐ parent
☐ legal guardian
☐ attorney for personal care

Mailing Address ▶ Apartment # | Street No. and Name or P.O. Box, Rural Route, General Delivery

City/Town | Postal Code

or ☐ same as Section 1

Residence Address ▶ Apartment # | Street No. and Name or Lot, Concession and Township

City/Town | Postal Code

or ☐ same as Section 1

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
X

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
X

Date *(yyyy/mm/dd)*

PHYSICIAN COPY