



## PATIENT ENROLMENT DATA

Before completing, please read our privacy policy to learn more about our practices regarding collecting, using, disclosing, protecting, and managing personal information. [www.windsorfht.ca](http://www.windsorfht.ca)

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: \_\_\_\_\_ Phone: \_\_\_\_\_

Former Family Physician: \_\_\_\_\_

Preferred Pharmacy Name/Location: \_\_\_\_\_

The Windsor Family Health Team is transitioning to a more digital approach for communication, which includes appointment reminders via email.

Please provide your email address: \_\_\_\_\_

By providing your email address, you agree to receive email communications from WFHT and Ocean by CognisantMD.

By submitting a completed enrolment form, you acknowledge that you have read and agree to our patient rights and responsibilities, as set out in our [Welcome Package](http://www.windsorfht.ca). A doctor-patient relationship is not established until you have had your first appointment. More information can be found on our website <http://www.windsorfht.ca/patient-info>

**Please list any medications you are currently taking**

Current Medications (Name/Dose/Frequency)	

**Please list previous surgeries and dates**

Previous Surgical History and Date Performed	

**Please list any allergies and their reactions**

Allergy/Reactions	

**Are there any other doctors or specialists involved in your care?**

Doctor/Specialty	

Information collected is to provide you with the best possible care. If you prefer to discuss a part of this form in person, please leave that section blank. This information will not be shared outside your circle of care without consent, unless legally required, nor will it be used to determine patient eligibility.

## Personal and Family Medical History

Please check all that apply. Left checkbox “myself” is if the illness or condition applies to you. The right check box is if there is a family history of an *immediate* family member. (Parent, Grandparents, Siblings, Children).

Condition	Myself	Family	Condition	Myself	Family
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Gerd	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cancer (describe below)	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Disorder (describe below)	<input type="checkbox"/>	<input type="checkbox"/>
COPD (lung disease)	<input type="checkbox"/>	<input type="checkbox"/>	Nerve/Muscle Disease	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Miletus	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Additional Comments:

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## Preventative Care

Have you had any of the following testing done? When?

### Screening

### Date (approximate if unknown)

- ☐ Blood Work
- ☐ Mammogram
- ☐ Pap Test
- ☐ Colorectal Screening (FIT Test, Colonoscopy)
- ☐ Other

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## **Social History**

### **Marital Status**

☐ Single      ☐ Married      ☐ Common Law      ☐ Divorced      ☐ Widowed

### **Smoking History**

Do you smoke cigarettes?      ☐ Yes      ☐ No      ☐ Quit

If yes, how many per day? \_\_\_\_\_

When did you start? \_\_\_\_\_

Former smoker? When did you quit? \_\_\_\_\_

How long did you smoke for? \_\_\_\_\_

### **Lifestyle**

How would you rate your diet?      ☐ Poor      ☐ Fair      ☐ Healthy

How often do you exercise?      ☐ Sometimes      ☐ Often      ☐ Frequently

Do you drink alcohol?      ☐ Yes      ☐ No      # Per week \_\_\_\_\_

Do you use drugs/substances      ☐ Yes      ☐ No

If yes, which substance?      ☐ Marijuana      ☐ Cocaine      ☐ Heroin

☐ Other

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Any other concerns you would like your health care provider to know?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## SOCIO-DEMOGRAPHIC FORM

Information collected will be used to identify who we serve in the community, and to promote equitable care. Equitable care incorporates unique needs that people may have based on language, income, gender, etc. Data collected is confidential and you may “prefer not to answer” for any question. If you choose to not answer, your care or access to services will not be affected. You can read more about our privacy policy on our website. [www.windsorfht.ca](http://www.windsorfht.ca)

Full Name: \_\_\_\_\_

***\*If you are a parent or a caregiver, please seek the consent of your child's or youth's approval before submitting this form. Please respond with "Prefer not to answer", if you have not received consent especially when answering gender and sexual orientation questions.***

***Thank you.***

***\*For more information about consent please see: <https://www.ipc.on.ca/part-x-cyfsa/consent-and-capacity/substitute-decision-makers/substitute-decision-makers-for-children-under-the-age-of-16/>***

**Please select the answers that best apply to you:**

### Age Range

- ☐ Under 18
- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65+
- ☐ Prefer not to answer

### Language

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

- ☐ English
- ☐ French/Francophone
- ☐ Arabic
- ☐ Italian
- ☐ Other: \_\_\_\_\_
- ☐ Prefer not to answer

**Were you born in Canada?**

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

**If NO, I have lived here for...**

- ☐ Less than 1 year
- ☐ 1-3 years
- ☐ 4-10 years
- ☐ 10+ years
- ☐ Prefer not to answer

**What is your race/ethnicity?**

- |   |  |
|---|--|
| <input type="checkbox"/> Asian-East (Chinese, Japanese, Korean)                   | <input type="checkbox"/> First Nations         |
| <input type="checkbox"/> Asian-South (Indian, Pakistani, Sri Lankan)              | <input type="checkbox"/> Indigenous/Aboriginal |
| <input type="checkbox"/> Asian-South East (Malaysian, Filipino, Vietnamese)       | <input type="checkbox"/> Inuit                 |
| <input type="checkbox"/> Black-African (Ghanaian, Kenyan, Somali)                 | <input type="checkbox"/> Metis                 |
| <input type="checkbox"/> Black-Caribbean (Barbadian, Jamaican)                    | <input type="checkbox"/> Oceania               |
| <input type="checkbox"/> Black-North American (Canadian, American)                | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Indian-Caribbean (Guyanese with origins in India)        | <input type="checkbox"/> Unknown               |
| <input type="checkbox"/> Latin/Central America (Argentinian, Chilean, Salvadoran) | <input type="checkbox"/> Prefer not to answer  |
| <input type="checkbox"/> Middle Eastern/West Asian (Egyptian, Iranian, Lebanese)  |  |
| <input type="checkbox"/> White-European (English, Italian, Portuguese, Russian)   |  |
| <input type="checkbox"/> White-North American (Canadian American)                 |  |

**Do you have any of the following disabilities? (Check all that apply)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Chronic Pain         | <input type="checkbox"/> Developmental       | <input type="checkbox"/> Mental Illness           |
| <input type="checkbox"/> Chronic Illness      | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Drug/Alcohol Dependence  |
| <input type="checkbox"/> Degenerative Disease | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Sensory (Vision/Hearing) |
| <input type="checkbox"/> None                 | <input type="checkbox"/> Do not know         | <input type="checkbox"/> Prefer not to answer     |

**How would you describe your gender?**

- |   |   |
|---|---|
| <input type="checkbox"/> Male               | <input type="checkbox"/> Two-Spirit           |
| <input type="checkbox"/> Female             | <input type="checkbox"/> Non-Binary           |
| <input type="checkbox"/> Transgender Male   | <input type="checkbox"/> Do not know          |
| <input type="checkbox"/> Transgender Female | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Gender Fluid       | <input type="checkbox"/> Prefer not to answer |

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

**What are your preferred pronouns?**

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> He/Him    | <input type="checkbox"/> Do Not Know                   |
| <input type="checkbox"/> She/Her   | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> They/Them | <input type="checkbox"/> Prefer not to answer          |

These questions are included to allow children and youth the opportunity to voluntarily and consensually self-identify their current lived gender identity. At any time, a child or youth may request a correction to their identity-based data.

### What is your sexual orientation

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

This question is included to allow children and youth the opportunity to voluntarily and consensually self-identify their current sexual orientation. At any time, a child or youth may request a correction to their identity-based data.

### What was your total household income before taxes last year?

*\*If you are under 18 years old, this question refers to the household income supporting you.*

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

### How many people does this income support? \_\_\_\_\_

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Do not know | <input type="checkbox"/> Prefer not to answer |
|--------------------------------------|---|

### Do you have difficulty making ends meet with this income?

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

### Based on your answers, would you like to be connected to community resources?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

Thank you for your participation. Your feedback helps us serve you better