Maywood Medical

4980 Kingsway, Unit 110
Burnaby, BC V5H 4K7
Tel: 604-243-7880
Fax: 604-243-7881
maywoodmedical.com

NEW PATIENT PRE-REGISTRATION FORM

Please complete this form to the best of your abilities and comfort level. This will create a better frame for discussion at your initial visit and will enable your doctor to get to know you.

I. Demographic

Surname: _____ First Name: _____

Gender: _____ DOB (mm/dd/yyyy): _____

PHN: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Primary Phone Number: _____

Secondary Phone Number: _____

Email: _____

Emergency Contact Name: _____ Contact Number: _____

Do you need a translator? _____

Please indicate the language spoken if you are bringing an translator: _____

If you were referred, indicate by whom, the relationship, and if they are an existing patient:

Family: _____ ☐ currently a patient

Other: _____ ☐ currently a patient

If other family members are pre-registering as well, please list their names and have each of them complete this form:

_____

Who is your current family doctor?

Dr. _____ Clinic: _____

City: _____ Province: _____

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II. Past Medical History

Please list your medical conditions if you have been diagnosed with any of the following:

1. Eye problems, including glaucoma, cataract, macular degeneration, or other:

   _____

2. Cardiovascular problems, including high blood pressure, heart attack, heart failure, aneurysm, rhythm problems (atrial fibrillation, pacemaker), or other:

   _____

3. Respiratory problems, including asthma, chronic bronchitis, emphysema, or other:

   _____

4. Ear, nose, or throat problems, including hay fever, sinusitis, otitis, laryngitis, or other:

   _____

5. Gastrointestinal problems, including acid reflux, ulcers, colitis, diverticulitis, or other:

   _____

6. Kidney problems, including kidney failure, stones, cysts, or other:

   _____

7. Liver problems, including hepatitis, fatty liver, cirrhosis or other:

   _____

8. Gynecological problems, including fibroids, endometriosis, or other:

   _____

9. Urological problems, including bladder issues, enlarged prostate, or other:

   _____

10. Hematologic (blood) problems, including clots, lymphoma, anemia, or other:

    _____

11. Endocrine (glandular) problems, including diabetes, thyroid disease, or other:

    _____

12. Musculoskeletal/rheumatological (joint) problems, including chronic pain, osteoarthritis, rheumatoid arthritis, lupus, or other:

    _____

13. Neurological problems, including dementia, Parkinson's, strokes, or other:

    _____

14. Mental health problems, including ADHD, anxiety, depression, bipolar, or other:

    _____

15. Cancer of any location, including breast, uterus, skin, prostate, colon, lung, or other:

    _____

16. Other medical problems:

    _____

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Please list any specialists that you see:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any surgeries you have had and the year(s) of operation:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do you have any allergies to the following:

- Medications: _____
- Other substances/food: _____

III. Medications

Please list all the prescription medications you currently take, including dosage and frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list all the over-the-counter medications and supplements you currently take:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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IV. Preventative Screening

If you have had any of the following, please indicate the last test date:

- Stool test for blood (FIT) date: _____
- Colonoscopy date: _____
- Mammogram* date: _____
- Pap smear* date: _____

*if applicable

Please comment on any abnormal results: _____

V. Family History

Please indicate which family member(s), if any, have the following medical conditions:

- heart attack or stroke _____
- diabetes _____
- cancers: breast, colon or other _____
- hepatitis _____
- genetic disorders _____
- autoimmune disorders _____
- hip fracture _____
- anxiety or depression _____
- bipolar _____
- schizophrenia _____
- suicide _____
- alcohol/substance abuse _____
- other _____

VI. Function

Patients with certain medical conditions or patients who are elderly may need additional support. Please indicate if you need assistance with any of the following:

- ☐ meal preparation
- ☐ ordinary housework
- ☐ managing finances
- ☐ managing medications
- ☐ phone use
- ☐ shopping
- ☐ transportation
- ☐ mobility in bed or transfers
- ☐ locomotion in or outside the home
- ☐ dressing upper and lower body
- ☐ eating
- ☐ toilet use
- ☐ personal hygiene
- ☐ bathing

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VII. Mental Health Screen

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Feeling nervous, anxious, or on edge	☐	☐	☐	☐

VIII. Substance Use History

1. Do you smoke?
   ☐ No ☐ Yes, _____ packs a day for _____ years
   I quit in _____ (year) after smoking for _____ years
2. How many alcoholic beverages do you drink in a week? _____ drinks
3. Do you use recreational substances? ☐ No ☐ Yes: _____

IX. Social History

1. Occupation (or prior occupation) _____
2. Are you: ☐ Retired ☐ Unemployed ☐ Leave of absence
   ☐ Disability: _____
3. Years of education or highest degree: _____
4. Do you have third party drug coverage? _____
5. Who lives at home with you? _____
6. Marital status: _____

X. Pediatrics (only for patients currently aged 0 - 12)

1. What was your birth weight? _____
2. What was your birth length? _____
3. What was your birth head circumference? _____
4. How many weeks gestation were you born at? _____
5. How were you delivered (vaginal birth, vacuum/forceps, cesarean section)? _____
6. Were there any complications during or around the time of labour? _____
   _____
7. What school do you currently attend? _____
8. What are the names of your parents/guardians? _____
9. Are your childhood immunizations up to date? _____

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Is there any other relevant information you would like to add?

Please bring the completed form to Maywood Medical or email this form to info@maywoodmedical.com with the subject line "New Patient - *Last Name*, *First Name*".

We endeavour to use reasonable means to protect the security and confidentiality of information received. By submitting this form, you agree to release our office and any personnel working at our office from any liability of the risk of information disclosed to third parties beyond our control.

You will be invited to book a first appointment when you come off the pre-registration waiting list. Submission of this form is not a guarantee that you will be matched with a family physician.

Due to a high number of inquiries, DO NOT contact the clinic to inquire about your place in line or it may result in the lowering of your priority.

由於申請人數眾多，請勿打電話或電郵至診所查詢您目前申請的情況，不然有可能會影響到您的優先權。

Do số lượng yêu cầu cao, ĐỪNG liên hệ với phòng khám để hỏi về vị trí của bạn trong hàng hoặc nó có thể làm giảm mức độ ưu tiên của bạn.