Kawartha North
Family Health Team

Last Name (as appears on Health Card) ______________________________

First Name ________________ Preferred Name ____________________

Male ☐ Female ☐ Birthday (D/M/Y) _______ Current Dr./Nurse Practitioner ☐ Y ☐ N

If Yes, who? ________________ Where? ____________________

Health Card # ____________________ Expiry __________________

Mailing Address ____

______________________________ Postal Code ____________

Home Phone ________________ Cell Phone ___________________

May we leave a message about cancellations/closures, etc. on your phone? ☐ Y ☐ N

May we leave confidential messages about results, etc. on your phone? ☐ Y ☐ N

Employment status: Retired ☐ Employed ☐ Self-employed ☐ Unemployed ☐ Student ☐

Marital Status: Single ☐ Married / Common Law ☐ Widowed ☐ Separated / Divorced ☐

Do you smoke or use tobacco? ☐ Y ☐ N How many per day? __________

If no, did you ever smoke? ☐ Y ☐ N How long? ______ When did you quit? ______

Do you drink alcohol? ☐ Y ☐ N How many per week? __________

Medical History: (***please attach separate page if necessary)***

Illness, disease or condition	**When was this diagnosed?**

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Medication(s): (***attach pharmacy printout if possible)***

Medication Name *e.g. Lipitor*	**Dose** *e.g. 20mg*	**How many** *e.g. 1 tablet*	**Frequency?** *e.g. once daily*

Vaccination History:

Type	**Month/Year**
Influenza (flu vaccine)	
Prevnar 13, Pneumovax (pneumonia vaccine)	
Tetanus	
Zostavax (Shingles vaccine)	
Other:	

Preventative care:

	Year
Pap / Cervical Cancer screening	
Mammogram	
Bone Density	
Prostate test	
Colonoscopy	
FOBT (take home stool sample test)	

Allergies ______________________________ None ☐

Signature ______________________________ Date ______________

Please note, failure to complete this application in full may result in delays!