

Six Nations Family Health Team
P.O. Box 5000
Ohsween, Ontario
N0A-1M0
Phone # 519-445-4019 Fax # 519-445-1917

New Patient Intake Screening Form

Please fill out 1 form for each person

Name Homer Simpson M/ Phone # 519-445-1212
D.O.B 1-Jul-69 Cell Phone # 2893624565
Health Card # 258525658 Alternate Contact # 905-765-0022
Previous Family Dr. Dr. Kean
Next of Kin Marg Simpson

Past Health Issues

(examples might include surgeries, any hospitalizations, abnormal tests, any special tests and why ordered, cancers, heart problems, mental health issues., ie depression, anxiety)

Had Gall bladder out in 1999, Depression in 2000 and treated for

Current Health/Medical Issues

(mark with X)

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	Respiratory illness
X	Diabetes	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Heart disease
X	High BP	<input type="checkbox"/>	Mental Health	<input type="checkbox"/>	heart burn (reflux)
<input type="checkbox"/>	other(please explain)				

Current Medications (include medications that you are taking, with dosage and how often. Please attach a list or bring all medications to initial intake visit).

Name of Medication	Dosage mg	How often per day
Metformin	500 mg	2 times a day
Altace	25 mg	once a day
Multivitamin		once per day
Colace	100 mg	twice a day

Any other relevant information you would like the physician to know? Is there an issue you would like addressed on first visit?

Have a long standing lower back ache for last four months.

Thank you for completing this much needed information. You will be notified of your initial visit once your intake has been approved by the Physician.

Sincerely, Six Nations Family Health Team

Drop form off at the Family Health Team or email to snfht@sixnations.ca

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D.O.B _____ Cell Phone # _____
Health Card # _____ Alternate Contact # _____
Previous Family Dr. _____
Next of Kin _____

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Current Health/Medical Issues

(mark with X)

_____ Asthma	_____ Menstrual Problems	_____ Respiratory illness
_____ Diabetes	_____ Arthritis	_____ Heart disease
_____ High BP	_____ Mental Health	_____ heart burn (reflux)
_____ other(please explain)	_____	

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Name of Medication	Dosage mg	How often per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

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