Algoma
Nurse Practitioner-Led Clinic

Updated February 20, 2018

WELCOME TO THE ALGOMA NURSE PRACTITIONER-LED CLINIC

PLEASE READ

You must complete your initial intake appointment with your nurse practitioner before you are considered a registered patient of the clinic. We are not able to refill any medications including narcotics or address any of your medical concerns until after you have your intake appointment. If you have any urgent concerns, please seek care at Sault Area Hospital or a walk-in- clinic.

I have read and understand this. Please initial in the box. ☐

PATIENT REGISTRATION & QUESTIONNAIRE FORM

LAST NAME ______________________ FIRST NAME ______________________

DATE OF BIRTH DD / MM / YYYY ______________________ IDENTIFIED GENDER ______________________

OHIP NUMBER 1234 – 123 – 123 – XX ______________________ EXPIRY DATE ______________________

MAIN PHONE NUMBER ______________________ ALTERNATE PHONE NUMBER ______________________

STREET ADDRESS ______________________

APARTMENT/UNIT NUMBER ______________________

TOWN/CITY ______________________ PROVINCE ____________ POSTAL CODE ____________

EMERGENCY CONTACT NAME ______________________

RELATIONSHIP TO YOU ______________________ PHONE NUMBER ______________________

NAME AND LOCATION OF PREVIOUS PROVIDER ______________________

WHERE HAVE YOU BEEN RECEIVING CARE IN THE PAST FIVE (5) YEARS?

____

WHEN WAS THE LAST TIME YOU VISITED A HEALTH CARE PROVIDER & WHO DID YOU SEE?

____

____

DO YOU CURRENTLY HAVE DRUG COVERAGE? YES ☐ NO ☐

IF YES, THROUGH WHICH COMPANY?

WHAT PHARMACY DO YOU USE? (NAME AND LOCATION)

DO YOU LIVE IN A GROUP, RETIREMENT OR A LONG TERM CARE HOME? YES ☐ NO ☐

IF YES, WHICH ONE?

WHAT LANGUAGE(S) DO YOU SPEAK?

DO YOU HAVE ANY ALLERGIES/INTOLERANCES? YES ☐ NO ☐

IF YES, PLEASE LIST ALLERGEN AND REACTION BELOW; (PLEASE INCLUDE MEDICATION, LATEX, ENVIRONMENTAL, ETC.)

IMMUNIZATIONS		
FLU	DATE	
GARDASIL (HPV VACCINE)	DATE	
HEPATITIS A	DATE	
HEPATITIS B	DATE	
MMR (MEASLES, MUMPS, RUBELLA)	DATE	
PNEUMOCOCCAL	DATE	
TB SKIN TEST; POSITIVE ☐ NEGATIVE ☐	DATE	
TETANUS, DIPHTHERIA – WITH OR WITHOUT WHOOPING COUGH (CIRCLE ONE)	DATE	
TWINRIX	DATE	
VARICELLA (CHICKEN POX)	DATE	
OTHER	DATE	

HAVE YOU BEEN HOSPITALIZED IN THE PAST 2 YEARS? YES ☐ NO ☐

PERSONAL MEDICAL HISTORY – PLEASE CHECK ANY THAT APPLY

	Y/N	YEAR DIAGNOSED		Y/N	YEAR DIAGNOSED
ACID REFLUX			HIGH BLOOD PRESSURE		
ALCOHOLISM			HIGH CHOLESTEROL		
ANEMIA			HEART ATTACK		
ANOREXIA			KIDNEY DISEASE		
ARTHRITIS			LIVER DISEASE		
ASTHMA			LUPUS		
ATRIAL FIBRILLATION			MIGRAINE		
BELL'S PALSY			MUMPS		
BLOOD CLOTS			OBESITY		
BULEMIA			OSTEOPOROSIS		
CANCER			PERIPHERAL ARTERY DISEASE		
CHICKEN POX			PROSTATE ISSUES		
COPD			SEIZURE		
CONGESTIVE HEART FAILURE			SEXUALLY TRANSMITTED DISEASE		
DIABETES			SLEEP APNEA		
DRUG ADDICTION			STROKE		
ECZEMA			THYROID		
EMPHYSEMA			ULCERS OF THE STOMACH		
HEPATITIS			OTHER:		
HIV					

FAMILY HEALTH HISTORY

FAMILY MEMBER	LIVING (L) DECEASED (D)* UNKNOWN (U)	MEDICAL CONDITION (EXAMPLES; PREMATURE HEART DISEASE, DIABETES, MELLITUS, CANCER OF ANY TYPE; PROSTATE, BREAST, OR OVARIAN ISSUES, ETC.)
MOTHER		
FATHER		
MOTHER'S MOM		
MOTHER'S DAD		
FATHER'S MOM		
FATHER'S DAD		
SISTER		
BROTHER		

*IF DECEASED, PLEASE INDICATE AGE

MEDICATIONS & SUPPLEMENTS – Please contact your pharmacy to request an ACTIVE medication list print out and attach it to this form.
(Please list any supplements you are taking below)

HOW PHYSICALLY ACTIVE ARE YOU? NOT ☐ 1-2X PER WEEK ☐ 3-4X PER WEEK ☐ 5-7X PER WEEK ☐

DO YOU HAVE ANY SPECIAL DIETARY NEEDS? YES ☐ NO ☐

IF YES, WHAT?

DO YOU DRINK CAFFEINATED BEVERAGES? (IE. TEA, COLA, COFFEE) YES ☐ NO ☐

IF YES, HOW MANY PER DAY?

DO YOU CONSUME ALCOHOL? YES ☐ NO ☐

IF YES, HOW MANY STANDARDS DRINKS PER DAY? (IE. 12oz BEER / 1.5oz SHOT OF 40% LIQUOR / 5oz WINE = 1 STANDARD DRINK)

SMOKING STATUS

NON-SMOKER ☐ CURRENT SMOKER ☐ EX-SMOKER ☐ SMOKE-FREE SINCE?

IF CURRENT, HOW MANY CIGARETTES PER DAY? LESS THAN 5 ☐ 5-10 ☐ 10-20 ☐ 20+ ☐

DO YOU USE CHEWING TOBACCO? YES ☐ NO ☐

DRUG USE (RECREATIONAL) YES ☐ NO ☐

IF YES, WHAT AND HOW OFTEN?

MENTAL HEALTH

OVER THE LAST MONTH, HAVE YOU GOTTEN LESS PLEASURE FROM THINGS YOU USED TO ENJOY? YES ☐ NO ☐

OVER THE LAST MONTH, HAVE YOU BEEN FEELING SAD OR BLUE? YES ☐ NO ☐

DO YOU HAVE A HISTORY OF;

ABUSE	YES ☐ NO ☐	DEPRESSION	YES ☐ NO ☐
ADDICTION	YES ☐ NO ☐	GRIEF/TRAUMA (LOSS/ACCIDENT)	YES ☐ NO ☐
ANXIETY	YES ☐ NO ☐	SCHIZOPHRENIA	YES ☐ NO ☐

HAVE YOU EVER BEEN SEEN FOR OR ARE CONCERNED ABOUT;

A LEARNING DISABILITY	YES ☐ NO ☐	ADD	YES ☐ NO ☐
FETAL ALCOHOL	YES ☐ NO ☐	ADHD	YES ☐ NO ☐

WOULD YOU BE INTERESTED IN THE FOLLOWING SERVICES;

COUNSELLING	YES ☐ NO ☐	PARENTING SUPPORT	YES ☐ NO ☐
REFERRALS	YES ☐ NO ☐	SUPPORT WITH OTHER SOCIAL SERVICES	YES ☐ NO ☐

HAVE YOU HAD ANY PAST INJURIES/FRACTURES?

INJURY/FRACTURE	YEAR

HAVE YOU HAD ANY PAST SURGERIES?

SURGERY	YEAR

FOR WOMEN ONLY

REGULAR MENSTRUAL CYCLE	YES ☐	NO ☐	NUMBER OF PREGNANCIES	
SPOTTING	YES ☐	NO ☐	NUMBER OF BIRTHS	
PRE-MENSTRUAL DYSPHORIC DISORDER	YES ☐	NO ☐	NUMBER OF ABORTIONS	
CURRENTLY USING BIRTH CONTROL	YES ☐	NO ☐	NUMBER OF MISCARRIAGES	

IF YES, WHAT KIND? ______________________ POSTMENOPAUSAL YES ☐ NO ☐

DO YOU HAVE AN OBGYN? YES ☐ NO ☐ IF YES, YEAR? ______________

IF YES, WHO? ______________________

ARE YOU INTERESTED IN PRECONCEPTION PLANNING? YES ☐ NO ☐

ARE YOU PLANNING TO HAVE A BABY IN THE NEAR FUTURE? YES ☐ NO ☐

YEAR OF LAST	YEAR	RESULT
PAP		NORMAL ☐ ABNORMAL ☐
BREAST EXAM		NORMAL ☐ ABNORMAL ☐
MAMMOGRAM		NORMAL ☐ ABNORMAL ☐
BONE DENSITY		NORMAL ☐ ABNORMAL ☐
FOBT		NORMAL ☐ ABNORMAL ☐
COLONOSCOPY		NORMAL ☐ ABNORMAL ☐

FOR MEN ONLY

YEAR OF LAST	YEAR	RESULT
FOBT		NORMAL ☐ ABNORMAL ☐
COLONOSCOPY		NORMAL ☐ ABNORMAL ☐

ANY OTHER INFORMATION YOU THINK IS IMPORTANT FOR US TO KNOW;

____

____

HOW DID YOU HEAR ABOUT US? ______________________

I confirm the information I have provided in this form to be complete, truthful and accurate.

Please initial in the box. ☐

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CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I,________________________understand that the Algoma Nurse Practitioner-Led Clinic (NPLC) is seeking my consent to collect, use and disclose my personal health for the purpose of providing primary care services. It is understood that when attending Ministry of Health and Long Term Care funded services, there will be a requirement of submitting some information regarding service usage to the ministry.

I understand that the Algoma NPLC will only collect, use and disclose my personal health information with my consent unless a particular collection, use or disclosure is permitted or required by law without my consent.

This consent includes permission for the Algoma NPLC to contact Health Care Connect on my behalf to verify my enrolment in the program. With my permission and successful registration with the NPLC, they may remove my name from the Health Care Connect program.

The Algoma NPLC takes your privacy seriously. All employees have signed a confidentiality agreement permitting them to access your personal and health information only when required for the provision of health services. Your personal and health information will only be shared with agencies outside of the clinic with your informed consent, when not directly pertaining to the provision of health services unless specifically allowed by law. Permission to share your information can be revoked by you at any time, in writing to the Algoma NPLC. The Algoma NPLC has a comprehensive privacy policy available for viewing upon your request.

I hereby authorize the Algoma NPLC to collect, use and disclose my personal health information for the purposes indicated above.

☐ I have read and understand the terms above

____________________	____________________	____________________
Name of Patient	Signature	Date

____________________	____________________	____________________
Witness	Signature	Date

If you are filling this form out on behalf of someone, please sign here;

____________________	____________________	____________________
Name of Guardian/ Decision-Maker	Signature	Date