Algoma
*Nurse Practitioner-Led Clinic*

# 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 _____ 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 & 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?

_____

WHICH PHARMACY DO YOU USE? (NAME AND LOCATION)

_____

DO YOU CURRENTLY HAVE DRUG COVERAGE? YES ☐ NO ☐

IF YES, THROUGH WHICH COMPANY? _____

HIGHEST LEVEL OF EDUCATION _____

OCCUPATION _____ EMPLOYER _____

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

IF YES, WHICH ONE? _____

WHAT LANGUAGES DO YOU SPEAK? _____

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

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

ALLERGEN: _____ REACTION: _____

ALLERGEN: _____ REACTION: _____

ALLERGEN: _____ REACTION: _____

ALLERGEN: _____ REACTION: _____

ALLERGEN: _____ REACTION: _____

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

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Updated Sept 15, 2018

FAMILY HEALTH HISTORY

| FAMILY MEMBER | LIVING (L) DECEASED (D)* UNKNOWN (U) | MEDICAL CONDITION (EXAMPLES; DIABETES MELLITUS, CANCER & TYPE; HIGH BLOOD PRESSURE; HEART ATTACK; STROKE, ETC. PLEASE INCLUDE AGE @ DIAGNOSIS IF KNOWN) |
|---|---|---|
| MOTHER | | |
| FATHER | | |
| MOTHER'S MOM | | |
| MOTHER'S DAD | | |
| FATHER'S MOM | | |
| FATHER'S DAD | | |
| SISTER | | |
| BROTHER | | |

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

PERSONAL MEDICAL HISTORY – PLEASE CHECK ANY THAT APPLY

| | CHECK √ | YEAR DIAGNOSED | | CHECK √ | YEAR DIAGNOSED |
|---|---|---|---|---|---|
| ACID REFLUX | | | HEART ATTACK | | |
| ALCOHOLISM | | | KIDNEY DISEASE | | |
| ANEMIA | | | LIVER DISEASE | | |
| ANOREXIA | | | LUPUS | | |
| ANXIETY | | | MIGRAINE | | |
| ASTHMA | | | MUMPS | | |
| ATRIAL FIBRILLATION | | | OBESITY | | |
| BELL'S PALSY | | | OSTEOPOROSIS | | |
| BIPOLAR DISORDER | | | OSTEOARTHRITIS | | |
| BLOOD CLOTS | | | PERIPHERAL VASCULAR DISEASE | | |
| BULEMIA | | | PROSTATE ISSUES | | |
| CANCER | | | PTSD | | |
| COPD | | | SCHIZOPHRENIA | | |
| CONGESTIVE HEART FAILURE | | | SEIZURES | | |
| DEPRESSION | | | SEXUALLY TRANSMITTED DISEASE | | |
| DIABETES | | | SLEEP APNEA | | |
| DRUG ADDICTION | | | STROKE | | |
| ECZEMA | | | THYROID | | |
| HEPATITIS | | | ULCERS OF STOMACH | | |
| HIV | | | OTHER: | | |
| HIGH BLOOD PRESSURE | | | OTHER: | | |
| HIGH CHOLESTEROL | | | OTHER: | | |

MEDICATIONS & SUPPLEMENTS – Please contact your pharmacy to request an ACTIVE medication list printout and attach it to this form. Please also list any supplements or OTC medications you are taking below.

_____

_____

_____

_____

LIFESTYLE:

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 STANDARD DRINKS PER DAY? (IE. 12 OZ BEER/ 1.5 OZ SHOT OF 40% LIQUOR/ 5 OZ WINE = 1 STANDARD DRINK)

_____

SMOKING STATUS

NON-SMOKER ☐ CURRENT SMOKER ☐ EX-SMOKER ☐

IF CURRENT, HOW MANY CIGARETTES PER DAY? _____

YEAR STARTED SMOKING: _____

YEAR QUIT SMOKING: _____

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 |
|---|---|
| | |
| | |
| | |
| | |

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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 |
|---|---|---|