

Welcome To The Algoma Nurse Practitioner-Led Clinic

You must complete your initial intake or meet and greet appointment with a nurse practitioner for assessment. The nurse practitioner will review your conditions to determine if your needs are compatible with their scope of practice before you are considered a registered/enrolled 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 been accepted as a registered or enrolled patient of the clinic. 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

Algoma Nurse Practitioner-Led Clinic

443 Northern Avenue
Sault Ste. Marie, ON
P6A 5L3
Tel: 705-942-4711
Fax: 705-942-9687

Street Address

Apartment/Unit Number

Town/City

Province

Postal Code

Phone Number

Email Address

Emergency Contact Name

Emergency Contact Phone Number

Relationship To You

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, Retirement 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 <input type="checkbox"/> Negative <input type="checkbox"/>	Date
Tetanus, Diphtheria – With <input type="checkbox"/> Without <input type="checkbox"/> Whooping Cough	Date
Twinrix	Date
Varicella	Date
COVID-19: <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna	Date
<input type="checkbox"/> Johnson & Johnson <input type="checkbox"/> AstraZeneca	Date
Other	Date

Family Health History

Family Member	Living (L) Deceased (D)* Unknown (U)	Medical Condition <small>(Examples; Diabetes Mellitus, Cancer & Type; High Blood Pressure; Heart Attack; Stroke, Etc. Please Include Age @ Diagnosis If Known)</small>
Mother		
Father		
Mother's Mom		
Mother's Dad		
Father's Mom		
Father's Dad		
Sister		
Brother		

Have You Been Hospitalized In The Past 2 Years? Yes No

Personal Medical History (Please Check Any That Apply)

<input type="checkbox"/> Acid Reflux	Year Diagnosed _____	<input type="checkbox"/> Bipolar Disorder	Year Diagnosed _____	<input type="checkbox"/> Diabetes	Year Diagnosed _____
<input type="checkbox"/> Heart Attack	_____	<input type="checkbox"/> Osteoarthritis	_____	<input type="checkbox"/> Sleep Apnea	_____
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> Blood Clots	_____	<input type="checkbox"/> Drug Addiction	_____
<input type="checkbox"/> Kidney Disease	_____	<input type="checkbox"/> Peripheral Vascular Disease	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Bulemia	_____	<input type="checkbox"/> Eczema	_____
<input type="checkbox"/> Liver Disease	_____	<input type="checkbox"/> Prostate Issues	_____	<input type="checkbox"/> Thyroid	_____
<input type="checkbox"/> Anorexia	_____	<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Lupus	_____	<input type="checkbox"/> PTSD	_____	<input type="checkbox"/> Ulcers Of Stomach	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> COPD	_____	<input type="checkbox"/> HIV	_____
<input type="checkbox"/> Migraine	_____	<input type="checkbox"/> Schizophrenia	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Congestive Heart Failure	_____	<input type="checkbox"/> High Cholesterol	_____
<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Seizures	_____	<input type="checkbox"/> Other:	_____
<input type="checkbox"/> Atrial Fibrillation	_____	<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Other:	_____
<input type="checkbox"/> Obesity	_____	<input type="checkbox"/> Sexually Transmitted Disease	_____		
<input type="checkbox"/> Bell's Palsy	_____				
<input type="checkbox"/> Osteoporosis	_____				

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? (I.e: 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? _____

(I.e. 12 Oz Beer/ 1.5 Oz Shot Of 40% Liquor/ 5 Oz Wine = 1 Standard Drink)

Do You Consume Cannabis? Medical Recreational Frequency _____ Amount _____

Smoking Status

Non-Smoker Current Smoker Ex-Smoker Vape

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? _____

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Have You Had Any Past Injuries/Fractures?

Year

Have You Had Any Past Surgeries?

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 _____

Do You Have An OBGYN? Yes No Postmenopausal 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 <input type="checkbox"/> Abnormal <input type="checkbox"/>
Breast Exam		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Mammogram		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Bone Density		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
FOBT		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Colonoscopy		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>

For Men Only

Year of Last	Year	Result
FOBT		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>
Colonoscopy		Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>

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
- A.D.D. Yes No
- Fetal Alcohol Yes No
- A.D.H.D. 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

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.

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 below:

Name of Guardian/
Decision-Maker

Signature

Date