East St. Paul Medical Center - Family Medicine Patient Application

Please fill out as thoroughly as possible and return original copy in person to front desk of East St. Paul Medical Center

Name: ______________________________ Date: ______________

Birthdate: ______________ Preferred Gender: ______________

Address: ______________________________

Primary Contact Number: ______________ Secondary Contact Number: ______________

Email Address*: ______________________________

Primary Pharmacy (with address): ______________________________

*Will be kept on file for future appointment confirmations if applicable

Past Medical History:

- ☐ Abnormal Heart Rhythm
- ☐ Acid Reflux
- ☐ Arthritis
- ☐ Asthma
- ☐ Anxiety
- ☐ Bipolar
- ☐ Bladder Infection
- ☐ Blood Clots
- ☐ Bleeding Tendency
- ☐ Breast Disease
- ☐ Cancer - Type: ______________
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Dementia
- ☐ Dental Disease
- ☐ Depression
- ☐ Diabetes - Insulin Dependent? ☐ yes ☐ no
- ☐ Eating Disorder
- ☐ Gallbladder Disease
- ☐ Gastritis/Ulcer Disease
- ☐ Gastrointestinal Bleed
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Migraines
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Serious Trauma
- ☐ Stroke
- ☐ Substance Abuse - Type: ______________
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Varicose Veins

Other: ______________________________

If "yes" to any of the above, please list year of diagnosis, any past or ongoing treatment, and any details you believe are important: ______________________________

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List **hospitalizations**, including date of and reasons for hospitalization: ______________________________

____

____

Allergies:

Please list any drug or medical material (latex) allergies and the associated reaction: ______________

____

Surgeries:

List the specific type of surgery and the date or age at time of surgery:____________________

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____

Medications:

List any prescription medications (with dosage and frequency of use) you are now taking:____________

____

____

____

Are you on any blood thinners? ◻ yes ◻ no ◻ do not know

List any self-prescribed medications, dietary supplements, or vitamins (with dosage and frequency of use) you are now taking:____

____

____

Family History:

Considering the illnesses listed under "Past Medical History" and any others, list any illnesses present in blood relatives (parents, siblings, grandparents):______________________________

____

____

Immunization History:

Are your immunizations up to date? ◻ yes ◻ no ◻ do not know

When was your last tetanus shot?____________________

When was your last flu shot?____________________

Have you ever had the shingles vaccine?____________________

Have you ever been vaccinated for HPV? ◻ yes ◻ no ◻ do not know

If you're over the age of 65, have you received your pneumonia vaccines? ◻ yes ◻ no ◻ do not know

Screening History:

If you are 50 years old or greater, have you ever been screened for:

Breast Cancer? (if applicable): ◻ yes ◻ no ◻ do not know When?:____________________

Colon Cancer? ◻ yes ◻ no ◻ do not know When and how? (FOBT vs colonoscopy):____________________

Health and Lifestyle History:

Do you smoke? ◻ yes ◻ no

If yes, how many/many packs per day? ____________ Age started: ____________ Have you ever quit? ◻ yes ◻ no

Are you concerned about your own or someone else's alcohol use? ◻ yes ◻ no

If you answered "yes" for yourself, then please answer the next four questions:

Have you ever felt you should cut down on your drinking? ◻ yes ◻ no

Have people annoyed you by criticizing your drinking? ◻ yes ◻ no

Have you felt guilty about your drinking? ◻ yes ◻ no

Have you ever had a drink first thing in the morning to calm yourself or get rid of a hangover? ◻ yes ◻ no

Health and Lifestyle History Continued:

What is your marital status? ☐ Married ☐ Common Law ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Other: ________

Do you have any children? ☐ yes ☐ no

If yes, how many? ____________________

Are you currently working? ☐ yes ☐ no

If yes, what do you do? ____________________

If no, are you: ☐ a stay at home caregiver? ☐ retired? ☐ on benefits? ☐ on disability?

Do you often have the feeling of being overwhelmed or depressed? ☐ yes ☐ no

Have you ever sought the help of a counsellor or therapist? ☐ yes ☐ no

On average, how many hours of sleep do you get per night? ____________________

Do you exercise? ☐ yes ☐ no

If "yes", then please answer the following:

Type of exercise: ____________________

Frequency of exercise: ____________________

Please provide an example of what you eat on any given day: ____________________

____

____

Do you drink caffeinated beverages? ☐ yes ☐ no How many cups/cans/glasses per day? ____________

What are your personal health goals? (This can be physical, mental, spiritual, or emotional): ____________

____

____

____

Sexual History:

Have you ever been sexually active? ☐ yes ☐ no

Are you currently sexually active? ☐ yes ☐ no

Complete the following questions if you answered "yes" to the above question:

Are you having sexual relations with one or multiple partners? ☐ one ☐ multiple

Is it a monogamous relationship? ☐ yes ☐ no

How many partners have you had in the last year? ____________________

Is/Are your sexual partner(s): ☐ men ☐ women ☐ both

Do you and your partner(s) use contraception or protective methods? ☐ yes ☐ no If yes, what type? ____________

Have you ever had a sexually transmitted infection? (aka STI, for example - HPV, herpes, chlamydia, gonorrhea, or others?)

☐ yes ☐ no

List STI(s):____________________Treated? ☐ yes ☐ no

Gynecological History: (if applicable)

Do you get a period? ☐ yes ☐ no

If no, are you post-menopausal? ☐ yes ☐ no Have you experienced bleeding after menopause? ☐ yes ☐ no

If yes, when was the date of your last period? ____________

Is it regular? (approximately once per month) ☐ yes ☐ no

Number of days of flow: ____________________

Menstrual cramps: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Do you ever bleed in between your periods? ☐ yes ☐ no

Gynecological History Continued:

Date of last pap smear:________________ Results of last pap smear (if known):________________________________

Have you ever had an abnormal pap smear? ☐ yes ☐ no

If yes, explain what was done for further investigation and/or treatment: ________________________________

Number of pregnancies: __________________

Are you presently trying to become pregnant or will be trying soon? ☐ yes ☐ no

Symptoms:

Are you currently having or have you recently had any of the following symptoms?

- ☐ Abdominal pain
- ☐ Black stool
- ☐ Blood in stool
- ☐ Blood in urine
- ☐ Change in appetite
- ☐ Change in bowel habits
- ☐ Change in size/color of a mole
- ☐ Chest pain
- ☐ Constipation
- ☐ Coughing up blood
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Ear pain
- ☐ Eye pain
- ☐ Fatigue
- ☐ Fevers
- ☐ Headaches
- ☐ Hearing problems
- ☐ Heartburn
- ☐ Hoarse voice
- ☐ Inability to sleep flat
- ☐ Incontinence/Loss of urine
- ☐ Jaundice
- ☐ Leg cramps
- ☐ Lightheadedness
- ☐ Low back pain
- ☐ Memory problems
- ☐ Mood changes
- ☐ More frequent urination
- ☐ Muscle, bone or joint pain
- ☐ Nausea
- ☐ Night sweats
- ☐ Nosebleeds
- ☐ Numbness/tingling in extremities
- ☐ Palpitations/Irregular heartbeat
- ☐ Persistent bruising
- ☐ Persistent cough
- ☐ Rash
- ☐ Rectal pain
- ☐ Ringing in ears
- ☐ Sexual dysfunction
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Swelling of extremities
- ☐ Tremor
- ☐ Unexplained weight gain
- ☐ Unexplained weight loss
- ☐ Vision problems
- ☐ Vomiting
- ☐ Weakness
- ☐ Wheezing

Others:____

Do you feel that any of the above symptoms are urgent and require prompt evaluation? ☐ yes ☐ no

If yes, which symptom(s):____

Thank you for completing this application.