Fraser Street Medical

FRASER STREET MEDICAL CLINIC – NEW PATIENT REGISTRATION FORM

www.fraserstreetmedical.com

email: appointments@fraserstreetmedical.com

Please fill this form out in its entirety before you come into the office. Key Info

Last Name		First Name	Initial(s)
Care Card Number		Date of Birth (MM/DD/YYYY)	
Address		City	Postal Code
Phone	Cell	Work	
	Home		
Email			
Previous Family Doctor		Reason for Leaving	

REVIEW OF SYSTEMS

Over the past 2 months, have you experienced any of the following (or similar) symptoms?
Please check and circle symptoms that apply.

Yes	No	
		1. GENERAL: change in weight, change in appetite, chills, fever, night sweats, fatigue, lethargy, persistent infections, tiredness
		2. SKIN: brittle nails, bruising, change in mole/wart, change in skin colour, hair loss, hives, itching, skin rash, sore(s) or wound(s) that will not heal.
		3. HEAD, EYES, EARS, NOSE, and THROAT: bleeding gums, blurry vision, difficulty swallowing, dizziness, double vision, dry eyes, ear infection or discharge, ear pain, eye pain, headache, hay fever or post nasal drainage, hearing difficulty, hoarseness, itchy or water eyes, ringing in ears, sinus trouble, sore throat, sore tongue or mouth.
		4. NECK: difficulty swallowing, pain, stiffness, swollen glands
		5. RESPIRATORY: congestion, coughing, coughing up blood, shortness of breath, snoring, sputum, wheezing
		6. BREAST: lump, nipple discharge, nipple pain, recent size change, swelling
		7. CARDIOVASCULAR: ankle swelling, chest pain, fainting, high blood pressure, light headedness, palpitations, shortness of breath
		8. GASTROINTESTINAL: abdominal pain, black bowel movement, blood in bowel movement, change in bowel pattern, constipation, diarrhea, excessive gas, heartburn, indigestion, nausea, vomiting
		9. GENITOURINARY: abnormal colour in urine, absence of menstruation, blood in urine, change in urinary stream, excessive menstrual bleeding, excessive non-menstrual bleeding, foul odour in urine, frequent urination, hot flashes, incontinence, menstrual irregularities, painful intercourse, painful menstruation, painful urination, sexual dysfunction, straining urination, testicular mass, testicular pain, urine leakage, vaginal bleeding, vaginal itching
		10. MUSCULOSKELETAL: back pain, decreased range of motion, loss of strength, muscle aches, painful joints, stiffness, swollen joints
		11. NEUROLOGICAL: dizziness, easily distracted, headaches, memory loss, numbness, seizures, spinning sensation, trouble walking
		12. PSYCHIATRIC: anxiety, change in sleep pattern, depression, insomnia, mood swings
		13. ENDOCRINE: cold intolerance, excessive thirst, heat intolerance, sweating
		14. HEMATOLOGY: abnormal bleeding, easy bruising, nosebleeds

HISTORY

Past Medical: List any chronic medical conditions you have (i.e. Diabetes, Hypertension, Asthma, etc.)

Allergies: List all allergies and the reaction they cause

Allergy	Reaction

Medication: List any medications you currently take on a daily basis including dosage and frequency

Medication	Dosage/Frequency	Medication	Dosage/Frequency

Social:

☐ Alcohol	How much/day:	☐ Tobacco	How much/day:	☐ Caffeine	How much/day:
☐ Sleep	How much/night:	☐ Drug use	How much/day: What Drugs:		
☐Exercise	How often: Activities:				

Reproductive: **Women only**

List the outcome of each pregnancy:	
Date of last Pap Smear:	Date of Last Mammogram:

Past Surgical: List any surgical procedure you have ever had, including year of procedure

Health Maintenance: Have you ever had and when.

Eye Exam:	Dental Exam:
Colonoscopy:	Bone Density:
Prostate Check:	

FSM PATIENT-PHYSICIAN AGREEMENT FOR NO SHOW POLICY AND LATE VISIT POLICY

To better manage your care and to ensure that we are able to function sustainably and see you in a reasonable time period, our No Show Policy and Late Visit Policy ***will be enforced at the discretion of the physician***.`

PATIENT'S RESPONSIBILITIES

1. Please email us at **appointments@fraserstreetmedical.com** or call 604.322.322.3366 and speak to the receptionist to cancel with ***at least 24 hours notice.***
2. Please show up ***5 minutes prior*** to your assigned appointment time to ensure you get parking and check-in on time.
3. Update your ***phone number and address*** with the receptionist.
4. You may be called in to review this policy in person with your physician if there is a pattern of No Shows or late appointments.

By signing this form, I hereby declare that I understand there is a No Show Policy/Late Appointment Policy at our clinic.

FOR **NO SHOWS,** THERE IS **A $30 NO SHOW FEE** WHICH MUST BE PAID PRIOR TO MY NEXT VISIT.

IF I SHOW UP **LATE FOR A SCHEDULED VISIT** AND THE PHYSICIAN HAS MOVED ONTO THE NEXT APPOINTMENT. I may be asked to come back later on the same day, or wait until the next available opening that day. If the doctor is not able to see me that day, there may be a $30 NO SHOW FEE.

Patient Signature _____ Date _____