FRASER STREET MEDICAL CLINIC – NEW PATIENT REGISTRATION FORM

Please fill this form out in its entirety before your visit or submit before you come into the office.

Last Name		First Name Preferred Pronoun:		Sex: Please Circle Male/Female/Other
Care Card Number		Date of Birth (MM/DD/YYYY)		
Address		City Vancouver	Postal Code	
Phone	Cell*	Work	Home	
	By completing, I consent to being contacted by text/SMS by the clinic staff and physicians*			
Email*	***By completing, I consent to being contacted by email by the clinic staff and physicians****			
Previous Family Doctor		Emergency Contact (Relationship and Number)		

REVIEW OF SYSTEMS Over the past 2 months, have you experienced any of the following (or similar) symptoms?
Please check YES/NO and circle any 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 drug allergies or serious food allergies and the reaction they cause

Allergy	Reaction

Medication: List any medications you currently take on a daily basis including dosage and frequency
By completing, I consent to having a Pharmanet search for my care by the clinic staff and physicians*

Medication	Dosage/Frequency	Medication	Dosage/Frequency

Social History:

Please Circle: Marital Status: Single/Married/Common-law/Divorced/Widowed					
☐ 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: Yes/No if you have had and what year?

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 sustainably of the clinic and in order 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. **TO CANCEL:** 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. **SHOW UP:** 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 required 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 due to a lack of time, at the discretion of the physician, there may be a $30 NO SHOW FEE charged.

Patient Signature _____ Date _____