HALIBURTON FAMILY MEDICAL CENTRE
Health Questionnaire
Please fill out one form for each person being seen

Last Name_____ First Name_____

Mailing Address_____911_____

City_____Postal Code_____Date of Birth: (D) ____(M)____(Y)_____

Health Card No._____ Version Code (letters at the end)____

Home Phone ( )_____ Work No. ( )_____Cell Number:_____
Email Address_____

Medical Problems: *(past and present)*

□Hypertension/Heart Disease/Stroke
□Lung disease/Asthma/Chronic Bronchitis
□Kidney disease
□Diabetes
□Depression/Anxiety
□Other (please list)

□Bowel/Stomach problems
□Arthritis
□Cancer
□Chronic Pain
□Substance/Tobacco Abuse

Past Surgeries:

Allergies to medications:

Medications: *(including pain medication/past or present)*

If required for additional information use back of sheet.

If you are a **female** over the age of 50 when was your last:
Mammogram_____Pap_____Colon Cancer Screen_____
If you are a **male** over the age of 50 when was your last:
Colon Cancer Screen_____
If you are **over 65** have you had a flu shot?_____

Please provide name of your most recent physician_____
Date last seen: _____

Signature:_____ Date:_____

Haliburton Highlands
Family Health Team
Your Pathway to Good Health

HALIBURTON FAMILY MEDICAL CENTRE
Box 870, Haliburton, Ontario K0M 1S0
TEL: (705) 457-1212 FAX: (705) 457-3955

MINDEN MEDICAL CENTRE
Box 700, Minden, Ontario K0M 2K0
TEL: (705) 286-2500 FAX: (705) 286-2022

Dr. N. Bottum Dr. R. Heyes Dr. T. Stephenson Dr. A. Conway Dr. M. Armstrong Dr. S. Ferraculi Dr. K. Gammon
Dr. S. Coles Dr. N. Cossons Dr. B. Varty Dr. J. Dawson Dr. D. Beattie Dr. J. Suke Dr. N. Thomas
Nurse Practitioners: K. McLaughlin V. Meraw S. Robinson

NEW PATIENT REQUEST

Last Name_____ First Name_____

Mailing Address_____

City_____Postal Code_____ Date of Birth: (D) ____(M)____(Y)_____

Health Card No._____Version Code (letters at the end)____

Home Phone ( )_____ Work No. ( )_____Cell Number:_____
Email Address_____

Family Members (who also need a local healthcare provider);

Name & Relationship	Health Card Number	Date of Birth

Do you have a family doctor? ☐ Yes ☐ NO

If you answered **Yes,** please give the name of your current physician:_____
Date last seen: _____

IF YOU DO NOT HAVE A FAMILY PHYSICIAN WE ASK THAT YOU CALL HEALTHCARE CONNECT AT 1-800-445-1822 OR VISIT THEIR WEBSITE AT:
http://www.health.gov.on.ca/en/ms/healthcareconnect/public/

Patient Signature:_____ Date:_____

For office use only: ER ☐ Yes ☐ No ☐ Other (Medical Centre)