

Today's Date: _____
mm dd yyyy

Name _____

Date of Birth: _____
mm dd yyyy

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: _____ Alternate Number: _____

Instructions for Contacting Client: _____

Emergency Contact (include Phone #): _____

Referred by: Self CMHA Worker _____ Other _____

CRITERIA

Do not have a family doctor at the time of presentation to the City Centre Health Care*

AND

Live in the catchment area bounded by Crawford Ave; Tecumseh Rd; Central Ave and Riverside Drive
(Provide an address that is within this catchment area in order to receive service from the NP or MD)

OR

No Family Doctor and have a diagnosis of serious mental illness (SMI) living anywhere in Windsor and
Essex County

OR

Presently have a Family Doctor (Will be considered but at a lower priority)

None of the above criteria met

1. What medical conditions do you have or have you had (please indicate year of diagnosis)?

Condition	Year	Condition	Year

2. What operations have you had (list operations and year of surgery)?

Condition	Year	Condition	Year

3. What hospitalizations have you had other than conditions/operations listed above?

4. When was your last visit to a Family Doctor? _____
5. When were you last admitted to the Hospital? _____
6. Do you currently see a Psychiatrist? Who? _____ Yes No

7. What medications are you taking (including over the counter products, vitamins, products from health food store or drug store, etc. taken on a regular basis)? **Please bring all medications with you on your first visit**

Name	Dose	How often?		Name	Dose	How often?

8. Please list any drug allergies **and the reaction** that you had to the drug.

Drug	Reaction		Drug	Reaction

9. Have you had a Tetanus shot in the last 10 years? Yes No Year _____

10. Have you ever smoked? Yes No

If **Yes**, please complete the following questions:

Yes, Quit in Year _____ ; I smoked _____ Packs per day for _____ years.

Yes, I still currently smoke; I smoke _____ Packs per day for _____ years.

11. Do you want to quit? Yes No If no, why not? _____

12. (WOMEN)

- a. Date of last menstrual period _____
- b. Are you now pregnant? Yes No
- c. How many Pregnancies have you had (including miscarriages)? _____
- d. When was your last pap smear? _____ Never had one
- e. Have you ever had an abnormal Pap? Yes No
If Yes, when and what treatment was done? _____
- f. Date of last mammogram? _____

Medical Health History

11. Have you ever had or been told you had any of the following conditions?:

Condition	Yes	No	Condition	Yes	No
Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Condition	Yes	No	Condition	Yes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>
Backache/Neckache, injury to back or neck	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease/hepatitis/jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Type:	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack, angina, chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism or addiction	<input type="checkbox"/>	<input type="checkbox"/>
Other heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Haemorrhoids/rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in breathing/shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Foot Problems	<input type="checkbox"/>	<input type="checkbox"/>
Eczema, skin problems, hives	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems (other than needing glasses)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>			
Problems with joints			Knee <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Wrist <input type="checkbox"/>		
Other:	_____				

11. Who has treated you for any of the conditions above?

FAMILY HISTORY

Does/did anyone in your family have any of the following conditions?

Condition	Yes	No	Who/age at diagnosis/Type
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression/Anxiety/Other Psychiatric Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please check the box next to the test(s) listed below that has been done in the past 10 years and indicate the most recent year the test was done.

Test	Year	Test	Year
Chest X-ray	<input type="checkbox"/> _____	Bone mineral density test	<input type="checkbox"/> _____
CT scan of _____	<input type="checkbox"/> _____	Echocardiogram	<input type="checkbox"/> _____
MRI of _____	<input type="checkbox"/> _____	Stress Test	<input type="checkbox"/> _____
Ultrasound of _____	<input type="checkbox"/> _____	Colonoscopy	<input type="checkbox"/> _____

Reason for Referral: Urgent Yes or No (If yes - list reason for urgent referral)

Specialist that you see/have seen in the past ten years:

<input type="checkbox"/> Psychiatrist	Dr. _____
<input type="checkbox"/> Gastroenterologist	Dr. _____
<input type="checkbox"/> Gynaecologist	Dr. _____
<input type="checkbox"/> Orthopaedic Surgeon	Dr. _____
<input type="checkbox"/> Neurologist	Dr. _____
<input type="checkbox"/> _____	Dr. _____
<input type="checkbox"/> _____	_____
<input type="checkbox"/> _____	Dr. _____