

Email:		Preferred Name:					
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Health Care Number:	Is this an Alberta Health Care Number? <input type="checkbox"/> Yes <input type="checkbox"/> No, Prov: _____	Home phone no.: ()		Birth date: (DD / MM / YR) / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			City / Province / Postal Code:		Cell/Alternate phone no.: ()		
			Your Occupation:		Your Work Phone: ()		
Spouse/Parent/Guardian's Name:			Relation:		Phone no.: ()		
How did you hear about Airdrie Medical Clinic?							

CLINIC INFORMATION (PLEASE USE BACK OF SHEET IF NECESSARY)		
Previous Doctor:	Reason for Change:	Surgical History / Medical Conditions:
Allergies (Drugs, Animals, etc.)	Habits: Do you smoke? (Y/N) _____ Years Smoking: _____ Years Quit Smoking _____ Alcohol: ___ drinks/wk Caffeine: ___ cups/day Regular Exercise: Yes / No	Family History: <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Other _____

CURRENT MEDICATIONS (INCLUDE ANY VITAMINS/HERBS AND OVER THE COUNTER MEDS) - USE BACK OF SHEET IF NECESSARY	
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge.			
Patient/Guardian signature		Date	