SYLVAN FAMILY HEALTH CENTRE
Forge a path. Change a life.

#101, 190 Pelican Place
Sylvan Lake, Alberta T4S 1K2
Phone: (403)887-2224 Fax: (403)887-2261
FAMILY PHYSICIANS
***Associate Professor Family Medicine U of A**

Dr. Fred H. Janke*	**B. Sc. M.D. M. Sc. F.C.F.P.**	**Dr. Brian Inglis**	**B. Sc. M.D.**
Dr. Muti Kauchali	**M.B. B.Ch. DFFP**	**Dr. Jordan LaRue**	**B. Sc. M.D. C.C.F.P.**
Dr. Ieleen S. Taylor	**B. Sc. M.D. C.C.F.P.**	**Dr. Julie Hernberger**	**B. Sc. M.D. C.C.F.P.**
Dr. Brad R. Bahler	**B. Sc. M.D. C.C.F.P.**	**Dr. Lindsay Nanninga-Penner**	**B. Sc. M.D. C.C.F.P.**
Dr. Stephen Swainson	**B. Sc. M.D. C.C.F.P.**	**Dr. Jessica Maciejko**	**B. Sc. M.D. C.C.F.P. M.Sc.**

Are you a new patient? Have you been here before but not for some time? Please take the time to update your medical history for us. The doctors often cover for each other, given the fact that not everyone works full time. It is important to have up-to-date medical information on file for you. Please check out our website sylvanfamilyhealth.com for further information on our clinic and our policies. This form is designed to help aid with data collection regarding your past history. We believe in the importance of keeping up-to-date medical information on patients and this is a tool we use to help achieve that goal. Please fill out the questions below in as much detail as possible.

Todays Date:

Name:

Who to notify in case of an emergency:

Relationship to you:

Phone Number(s):

Other Health Issues:

Caffeine Use: Coffee Tea Pop Yes No

Tobacco Use: Cigarettes Yes No
(If you have never smoked, please go to the Alcohol use section now)

Quit Date: _____ How many years did you smoke? _____

Approximately how many packs per day did you smoke? _____

Current Smoker: Packs per day: _____ Number of years: _____

Other Tobacco: Pipe: _____ Cigar: _____ Snuff: _____ Chew: _____

Alcohol Use:
Do you drink alcohol? Yes No

Number of drinks per week: _____ Beer: _____ Wine:_____ Liquor: _____

Drug Use:
Do you or have you used marijuana or other recreational drugs? Yes No

Have you ever used needles to inject drugs? Yes No

Exercise:
Do you exercise regularly? Yes No

If Yes, What kind of exercise? _____ How long per day? _____

Dairy Products: Yes No

If Yes, how many servings per day? _____ What type? _____

Social History:

Occupation (or prior occupation) _____

Circle one if applicable: Retired Unemployed Leave of Absence Disabled

Marital Status:

Please circle one: Single Common Law Married Divorced Widowed

Spouse/Partner's Name: _____

Number of Children:_____ Ages (if under 18): _____

Number of Grandchildren: _____ Number of Great Grandchildren: _____

Who lives at home with you? _____

Leisure activities, group involvement, volunteer work, recent travel:

_____

_____

_____

_____

_____

Women's Health History:

Total Number of Pregnancies: _____ Total Number of births: _____

Any complications with yourself or your baby: _____

Date (month/day if known) of last menstrual period if still menstruating: _____

Age at beginning of periods: _____ Age a end of periods (menopause): _____

Last PAP: _____ Any abnormal PAP's and when (year)? _____

Follow-ups? (ie. Colposcopy) _____ Repeat PAP 6 months? _____

Men's Health History:

Do you or have you had the following (please check if applicable):

Discharge from you penis: _____ Genital Pain: _____ Genital Infection: _____

Lump in testicles: _____ Low sex drive:_____Blood in sperm: _____

Problems with erections (please check if applicable):

Difficulty becoming erect: _____Difficulty maintaining erection: _____Erections not as firm: _____

Urinary Symptoms (please check if applicable):

Hesitancy: ____Urgency: _____Burning: _____Leaking: _____ Frequency: _____

Name of previous Health Care Provider: _____

Last Physical Examination and Where: _____

Last Bloodwork you had done and Where: _____

Fecal Occult Blood Screening – Where was it done? _____

Personal Medical History – Do you have now (current) or have ever had (past) any of the following conditions?

Condition	Current	Past	Comments
Alcohol/Drug Abuse			
Allergies (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Blood Clot (Leg)			
Blood Clot (Lung)			
Blood Transfusion			
Breast Lump (Benign)			
Cancer (Breast)			
Cancer (Colon)			
Cancer (Ovarian)			
Cancer (Prostate)			
Cancer (Other Type)			
Cataracts			
Chicken Pox			
Chronic Fatigue Syndrome			
Colon Polyp			
Coronary Artery Disease			
D & C			
Depression			
Diabetes (Adult Onset)			
Diabetes (Childhood Onset)			
Diverticulosis			
Emphysema			
Fibromyalgia			
Fractures (Broken Bones) What & When			
Gallbladder Disease			
Gastroesophageal Reflux(Heartburn/GERD)			
Glaucoma			
Gout			

Personal Medical History – Continued…

Condition	Current	Past	Comments
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Hearing Loss			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (Enlargement)			
Prostate (Nodules)			
Seizure/Epilepsy			
Skin Condition (Eczema)			
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive)/Hyperthyroidism			
Thyroid Low (Underactive)/Hypothyroidism			
Other (List)			
Other (List)			

Surgical History – Pease check off any procedure or surgery. List any abnormal findings or complications

Procedure	Year	Comments
Abdominal Surgery		
Appendectomy (Appendix Removal)		
Back Surgery (Lumbar)		
Biopsy (Specify Location)		
Breast Biopsy		Circle: Left Right Both
Breast Surgery		Circle: Left Right Both
C-Section		
Colonoscopy		
Coronary Bypass		
Coronary Stent		
EGD (Stomach Endoscopy)		
Cataract		
Gallbladder Removal		Circle: Laparoscopic
Heart Surgery (Other than Coronary Bypass)		
Hip Surgery		Circle: Left Right Both
Hysterectomy (Total, including ovaries)		Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (Partial, ovaries left)		Circle: Laparoscopic Vaginal Abdominal
Knee Surgery		Circle: Left Right Both
LEEP (Cervix Surgery)		
Neck Surgery		
Tubal Ligation		
Vasectomy		
Sigmoidoscopy		
Sinus Surgery		
Other (Please specify)		
Diagnostic Studies	**Date**	**Comments**
CT Scan (Specify number and body part)		
Bone Mineral Densitometry		
Mammogram		
MRI (Specify body part)		

Immunizations	Yes/No	Year(s)
Tetanus		
Pneumovax		
Flu Vaccine		
Hepatitis A		
Hepatitis B		

Name and location of the pharmacy you use:

Do you take any of the following medications? (Check yes or no)

Medications	Yes	No
Aspirin, Tylenol, Advil, Motrin		
Blood Pressure Pills		
Cortisone		
Cough Medicine		
Digoxin		
Hormones		
Insulin or Diabetic Pills		
Iron Medications		
Laxatives		
Sleeping Pills		
Thyroid Medicine		
Antihistamines (Benadryl, Reactine, Allegra)		
Anti-anxiety Medications (Xanax, Ativan)		
Tranquilizers (Valium)		
Weight Reducing Pills		
Blood Thinners		
Seizure Medications		
Any Injections, other than Insulin		
Water Pills		
Antibiotics		
Birth Control Pills		
Other (List)		

Please list any medications you are taking including the dose, how often you take it and the date you started. If you have or can obtain a list from you pharmacy, please attach.

Medication	Dosage	Number of times/day

Do you take herbal supplements? (Circle) Yes No

If Yes, please list below

Herbal Supplement	Dosage	Number of times/day

Do you take Vitamins? (Circle) Yes No

If Yes, please specify below

Vitamins	Yes	No
Multi-Vitamin		
Omega 3		
Calcium		
Vitamin B		
Vitamin C		
Vitamin D		
Vitamin/Mineral		
Other (List)		

Adopted? (Circle) Yes No If yes and you do not know your family history, pleases skip this section and continue to the next page.

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other	Comments
No significant history known										
Alcoholism										
Drug Abuse										
Alzheimer's										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer (Breast)										
Cancer (Colon)										
Cancer (Ovarian)										
Cancer (Prostate)										
Cancer (Other)										
Colon Polyp										
Coronary Artery Disease										
Depression/Anxiety										
Diabetes (Childhood Onset)										
Diabetes (Adult Onset)										
Emphysema (COPD)										
Genetic Disorder (Explain)										
Glaucoma										
Heart Disease (CHF)										
Hepatitis B or C										
High Blood Pressure-Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism/Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraines										
Osteoporosis										
Other (List)										

SYLVAN FAMILY HEALTH CENTRE
Forge a path. Change a life.

#101, 190 Pelican Place
Sylvan Lake, Alberta T4S 1K2
Phone: (403)887-2224 Fax: (403)887-2261
FAMILY PHYSICIANS
***Associate Professor Family Medicine U of A**

Dr. Fred H. Janke*	**B. Sc. M.D. M. Sc. F.C.F.P.**	**Dr. Brian Inglis**	**B. Sc. M.D.**
Dr. Muti Kauchali	**M.B. B.Ch. DFFP**	**Dr. Jordan LaRue**	**B. Sc. M.D. C.C.F.P.**
Dr. Ieleen S. Taylor	**B. Sc. M.D. C.C.F.P.**	**Dr. Julie Hernberger**	**B. Sc. M.D. C.C.F.P.**
Dr. Brad R. Bahler	**B. Sc. M.D. C.C.F.P.**	**Dr. Lindsay Nanninga-Penner**	**B. Sc. M.D. C.C.F.P.**
Dr. Stephen Swainson	**B. Sc. M.D. C.C.F.P.**	**Dr. Jessica Maciejko**	**B. Sc. M.D. C.C.F.P. M.Sc.**

REQUEST FOR RELEASE/TRANSFER OF MEDICAL INFORMATION
****PLEASE PRINT****

_____
Physician Name

_____
Name of Clinic & Location (city)

The patient(s) named below recently joined our practice and wishes to have information from his/her file transferred to our office.
Please forward photocopies of pertinent information. In particular, information related to:

_____

Patient Information:
Name: _____

Other (maiden) name: _____

Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

I understand that there may be a charge for the transferring or photocopying of my records. I further understand that it is my responsibility for any such charges incurred by my previous physician.

X_____ _____
Patient or Guardian Date

If guardian, relationship _____