CENTRAL LAMBTON FAMILY HEALTH TEAM

Dr. J. Butler Dr. E. Daniel Dr. F. Al-Dhaher,
Dr. J. Mall Dr. N. Taylor Dr. S. Cooper,
Dr. A. Leonard Dr. A. Hijazi Dr. P. Moon

4130 Glenview Ave., Unit 3
Petrolia, Ontario N0N 1R0 519-882-2500

Welcome to Central Lambton Family Health Team.
In order to serve you better, we ask that you complete the following:

Name:_____

Complete Mailing address: - Please include 911 number or P O Box

_____

_____

_____

Cell phone # (if applicable) _____

Employer Name _____ Phone #_____

EMERGENCY CONTACT:

Name: _____ Phone #_____

Relationship: _____

ALTERNATE CONTACT:

Name: _____ Phone #_____

Relationship: _____

PHARMACY USED FOR PRESCRIPTIONS

Pharmacy Name _____ Location _____

Previous Doctor _____ Location _____

We ask that you inform our office of any changes to the above information.

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REQUEST FOR MEDICAL RECORDS

Dear Dr: _____

The following patient has come under the care of Dr._____

( ) and would like a copy of his/her medical records transferred

( ) **does NOT wish** to have his/her medical records transferred and wishes to notify you of change ONLY

PATIENT : _____

DATE OF BIRTH: _____

OHIP NUMBER: _____

CURRENT ADDRESS: _____

_____

TELEPHONE: _____

I agree to release my medical records to Dr. _____.
I understand that there may be a charge for the transfer of records and I am aware that I will be responsible for any fees associated with transfer.

_____ _____
Patient signature (print name beside signature) Witness (print name beside signature)

_____ _____
Date Date

Central Lambton Family Health Team
4130 Glenview Road, Unit 3
PETROLIA, Ontario N0N 1R0
Telephone 519-882-2500 Fax 519-882-4321

Contact and Medical Information Sheet

_____ _____
Surname Given Name (s)

_____ _____ Gender (circle) Male Female X Another Gender
Date of Birth Age

_____ _____
Address: Number and Street Apt Number

_____ _____ _____
City Postal Code Home Phone No.

_____ _____ _____ ___ _____
Alternate Contact No. (eg cell) Type (ie. Work, cell) Health Card Number Version Expiry date

MEDICAL INFORMATION

Y	**N**	Diabetes: Type 1 Type 2	**Y**	**N**	Irritable Bowel Syndrome
Y	**N**	High Blood Pressure	**Y**	**N**	Heartburn, Indigestion, GERD
Y	**N**	High Cholesterol	**Y**	**N**	Crohn's Disease, Colitis
Y	**N**	Chest Pain, Angina	**Y**	**N**	Chronic Headaches
Y	**N**	Heart Failure	**Y**	**N**	Thyroid Disease: Hypothyroidism hyperthyroidism
Y	**N**	Heart Attack, when	**Y**	**N**	Lupus
Y	**N**	Emphysema	**Y**	**N**	Kidney Disease
Y	**N**	Asthma	**Y**	**N**	Hernia
Y	**N**	Problems with ears, eyes, nose	**Y**	**N**	Urinary/Bowel Incontinence ostomy colostomy
Y	**N**	Arthritis, joint pain: knees hips ankles wrist hands back Other:	**Y**	**N**	Have you ever had: Blood Clot, Deep Vein Thrombosis, Pulmonary Embolism
Y	**N**	Chronic Back Pain	**Y**	**N**	Fibromyalgia
Y	**N**	Anemia	**Y**	**N**	Skin Condition
Y	**N**	Sleep Apnea	**Y**	**N**	COPD
Y	**N**	Cancer	**Y**	**N**	Stroke
Y	**N**	Mental health issues: Anxiety Depression Panic attacks Bipolar Psychosis Schizophrenia PTS Other	**Y**	**N**	Other:
Y	**N**	Smoker Years smoking _____ Ex-smoker Year quit _____ If currently smoker, I would like to quit smoking (circle) yes no	**Y**	**N**	Drug Allergies : list and type of reaction (rash, nausea, anaphylaxis)

MEDICATIONS

Name	Dose	Frequency

PAST SURGERIES	DATE

FAMILY HISTORY OF SIGNIFICANT MEDICAL ISSUES EXAMPLE *diabetes*	RELATION *father*

Patient Declaration

Due to the current family doctor shortage, Patients without a current family doctor within Sarnia Lambton will be given a priority. Please check the box that most closely applies to you:

- □ My previous family physician has retired or moved
- □ My previous family physician is still practicing but no longer provides my care.
- □ Until now, I have not had or felt the need to have a family physician
- □ I have relocated to Sarnia-Lambton and do not have a family physician in the Community
- □ Other_____

Name of previous/current family physician: _____

Date last seen: _____ Location:_____

PLEASE NOTE:

- Completion of this form does not guarantee entrance into our practice.
- **Central Lambton Family Health Team will maintain a strict narcotic prescription policy in order to minimize the potential for abuse. Narcotics will only be prescribed for legitimate pain control purposes. Extended/prolonged narcotic prescription abuse will be warned and subject to termination of the patient-physician relationship.**

Please be sure this form is fully completed. Please fill out a separate form for each family member and return all forms together.

By signing below, I acknowledge I have read and understood all policies and procedures, as well as answered all questions truthfully. If responses on this form are intentionally incorrect, the patient-physician relationship may be terminated.

_____ _____

Signature Date