



ROSEWOOD
MEDICAL CLINIC

Alert! Did you check in with a receptionist first?

Date: _____

Last Name: _____ First Name: _____ AB Health Card No.: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: _____ Male ___ Female ___ other _____ Family doctor: _____

Home Number: _____ Cell Phone: _____ Work Number: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Medication Allergy: _____ Other Allergies: _____

E-Mail: _____

Current Medical History:

Wt _____ lbs / Kg Height _____ Cm / Inches / Feet

High Blood Pressure _____ Heart Disease _____ Depression _____ Anxiety _____

Diabetes _____ Type _____ High Cholesterol _____ Kidney Disease _____

Cancer _____ Type _____ Asthma _____ COPD _____ Obesity _____ Other: _____

List ALL medications, prescription, herbs, vitamins you're currently taking:

Past Surgeries/Procedures: Name ALL, including Year. Etc.: Wisdom teeth, Colonoscopy, Tonsil, Appendix.....

Family History: ex> Cancer (Type), Hypertension, Depression, Diabetes..... PLEASE include WHO in family,
Ex: Maternal/Paternal/grandparent/aunt/uncle....WHO???

Social

Occupation? _____

Do you exercise: YES NO How many times a week? _____

Do you smoke: YES NO How many cigarettes a day? _____ How many years? _____ Years Quit? _____

Do you drink alcohol: YES NO How many days per week? _____

Do you drink caffeine: YES NO How many times a day? _____

Do you use recreational drugs? YES NO What kind? _____ How Often? _____

Did you get the flu Vaccine this year? YES NO Want to get it Don't want

