



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



Patient Consent to use AI

Our clinic now uses software tools to assist in NOTE TAKING during clinic visits allowing you more time to have a quality chat with your doctor

- The use of AI software writes a summary to be reviewed by your doctor.
- AI does not keep the recording of the appointment.
- AI system will not use or save any of your personal information.

Patient Acknowledgment and Agreement

I have read this form and I consent using AI tools in my care and understand I can withdraw my consent at any time.

Signature:	Date:
Patient Name:	Guardian Name:

** Please return the form to the front desk when you're finished.*

