NEW PATIENT FORM

PATIENT INFORMATION:

Full Name: _____ Occupation: _____

Address: _____ City: _____ Province _____ Postal Code _____

Telephone: Home ( ) ____ - _____Work ( ) ____ - _____ **Mobile** ( ) _____ - _____

Sex: Male Female **Date of Birth**(YY/MM/DD) / / Email: _____

Marital Status: Single Married Widow **Height**:_____ **Weight**: _____

MEDICAL HISTORY:

	Yes	No		Yes	No		Yes	No
Angina/Chest pain	☐	☐	Hepatitis B	☐	☐	Cancer	☐	☐
Heart attack/failure	☐	☐	Hepatitis C	☐	☐	Type: _____		
Heart murmur	☐	☐	Liver failure	☐	☐	Muscular dystrophy	☐	☐
Heart valve problems	☐	☐	Lung disease	☐	☐	Type: _____		
Stroke	☐	☐	Asthma	☐	☐	Anemia	☐	☐
Bleeding problem	☐	☐	Seasonal allergies	☐	☐	Lazy eye	☐	☐
Diabetes	☐	☐	Inflammatory bowel dis	☐	☐	Glaucoma	☐	☐
High blood pressure	☐	☐	Alzheimer's disease	☐	☐	Retinal detachment	☐	☐
High cholesterol	☐	☐	Parkinson's disease	☐	☐			
Kidney failure	☐	☐	Thyroid problem	☐	☐	Hyper Hypo Euthyroid		
On Dialysis	☐	☐	Macular degeneration	☐	☐			

Additional Information? _____

FAMILY HISTORY:

	Yes	No		Yes	No		Yes	No
Heart disease	☐	☐	Thyroid disease	☐	☐	Cancer	☐	☐
Lazy eyes	☐	☐	Bleeding problem	☐	☐	Types: _____		
Retina disease	☐	☐	Anesthesia problem	☐	☐			

SOCIAL HISTORY:

	Never	Yes		Quit	
Smoke cigarette	☐	☐	_____ cigs/day ____ year	☐	When? _____
Smoke cigar	☐	☐	_____ cigs/day ____ year	☐	
Use Marijuana	☐	☐		☐	
Use Cocaine/Crack	☐	☐		☐	
Drinks Alcohol	☐	☐	_____ drinks/week	☐	

MEDICATIONS:

	Yes	No	OTHERS:	Dosage
Aspirin	☐	☐	_____	_____
Anti-inflammatory	☐	☐	_____	_____
Coumadin	☐	☐	_____	_____
Plavix	☐	☐	_____	_____
Fish Oil	☐	☐	_____	_____
Vitamin C or E	☐	☐	_____	_____

ALLERGIES:

	Yes	No
Penicillin	☐	☐
Sulfa	☐	☐
Codeine	☐	☐
Latex	☐	☐
Others:	☐	☐

SURGICAL HISTORY: (please include procedure and year)

_____

_____

_____

_____

PHYSICIAN INFORMATION: (Full Name)	City:	Phone:
Family Doctor: _____	_____	_____
Cardiologist: _____	_____	_____
Endocrinologist: _____	_____	_____
Other:_____	_____	_____

PHARMANET and PATHNET CONSENT:

Pharmanet and Pathnet allow computerized access to the drugs you are taking and the results of laboratory tests that you have had done. To check your current medication and avoid repeating lab tests unnecessarily, we would like your permission to access this information

My signature authorizes the office of Dr. Vivian T Yin to access my personal health information recorded elsewhere, for the purpose of providing care and treatment. This includes access to my PharmaNet medication profile and Pathnet laboratory information.

This consent will continue until such a time as I revoke this authorization in writing.

_____	_____	_____
Date Authorized	Patient Name (printed)	Patient Signature