Last Name: **First Name:** **Middle Name:**

DOB: **OHIP:** **My Age:**

Address:

Home Phone: **Cell Phone:** **Email:**

Preferred Pharmacy:

Current Health Problems (approximate date of onset):

-
-
-
-

Medications (names, doses, frequency of use):

-
-
-
-

Past Medical History (resolved problems, surgeries, MRIs, Scopes):

-
-
-
-

Family Medical Problems:

- Father
- Mother
- Siblings
- Children
- Grandparents

Allergies:

-
-
-
-

Specialists I See:

-
-
-
-

Other Issues:

-
-
-

Emergency Contact:

Relationship _____

Risk Factors:

- ☐ I Smoke or Vape
- ☐ I Drink Alcohol
- ☐ My Exercise Regimen
- ☐ My Job
- ☐ My Diet

Immunizations:

Last Tetanus Shot _____

Last Flu Shot _____

Last COVID Shot _____

Last Pneumonia Shot _____

This form is confidential when completed.

Please use back of form if required.

MyFamilyMD