DR. MADHANI INTAKE FORM

PLEASE COMPLETE THIS PRIOR TO YOUR APPOINTMENT Date: _____

Name: _____
(Name that appears on Health Card)

DOB:_____
DD/MM/YYYY

Email: _____

Last Occupation _____

Health Card No: _____

Retired: yes ☐ no ☐

Marital Status:
married ☐ divorced ☐
single ☐ common - law ☐

Pharmacy:
Name: _____
Phone:_____
Fax: _____

Who do you live with: _____

Lab:
Name: _____
Phone:_____
Fax: _____

Children Biological how many: _____

Family Dr: _____

Other Physicians you want reports copied to:

_____ _____

_____ _____

MUST BE COMPLETED PRIOR TO THE DOCTOR SEEING YOU ANSWER CORRECTLY ***DO NOT WITHHOLD INFORMATION*** SAFE CARE WILL BE PRIOVIDED REGARDLESS OF ANSWERS

TRAVEL HISTORY			
Have you travelled overseas in the last month?	☐ Yes ☐ No	Have you come in contact or do you live with a *known* or *suspected* case of COVID-19/ Corona Virus	☐ Yes ☐ No
Have you travelled to Wuhan China, Iran or Italy in the last 3 months?	☐ Yes ☐ No	Date(s) of travel: _____ _____ _____	
FEVER HISTORY			
In the last month have you had a measured fever	☐ Yes ☐ No	Highest Temp: _____ ☐ Celsius ☐ Fahren. Date of Temp: _____	
In the last month have you felt feverish	☐ Yes ☐ No	Last Date: _____	
SYMPTOMS **In the last month have you had/been:**			
Severe difficulty/struggle to breath	☐ Yes ☐ No	Breathless or are you speaking in single word sentences	☐ Yes ☐ No
New onset headache	☐ Yes ☐ No	Severe chest pain/tightness	☐ Yes ☐ No
Dry cough	☐ Yes ☐ No	Runny nose	☐ Yes ☐ No
Sore throat	☐ Yes ☐ No	Itchy or watery eyes	☐ Yes ☐ No
New onset chills	☐ Yes ☐ No	New onset muscle aches	☐ Yes ☐ No
New onset all over joint pain	☐ Yes ☐ No	New onset fatigue	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No	Diarrhea Onset: _____	
Vomiting	☐ Yes ☐ No		

REASON(S) YOU ARE HERE TODAY TO SEE DR. MADHANI IN YOUR OWN WORDS

_____

_____

_____

_____

_____

GOALS FOR TODAYS VISIT

_____

_____

_____

PAST MEDICAL CONDITIONS

1._____

2._____

3._____

4._____

5. _____

6. _____

7. _____

8._____

PAST SURGERIES INCLUDING DATES

1._____

2._____

3._____

4._____

5._____

6. _____

7. _____

8. _____

CURRENT MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION)

ARE YOU PRESENTLY TAKING ANTIOCOAGULATION MEDICATION: yes ☐ no ☐

YES list: _____

Name of Medication	**Dose**	**No. of Times Per Day Taken**
1._____	_____	____
2._____	_____	____
3._____	_____	____
4._____	_____	____
5._____	_____	____
6._____	_____	____
7._____	_____	____
8._____	_____	____
9. _____	_____	____
10._____	_____	____

DRUG ALLERIES

1._____ 2._____

3. _____ 4._____

FAMILY HISTORY - HEALTH CONDITIONS

FAMILY MEMBER	HEALTH CONDITION(S)		IF DECEASED, GIVE CONDITIONS FOR DECEASED
MOTHER			
FATHER			
		Number	
BROTHER(S)			
SISTERS(S)			
CHILDREN			
M. GRANDMOTHER			
M. GRANDFATHER			
P, GRANDMOTHER			
P. GRANDFATHER			
AUNTS/UNCLES			
FIRST DEGREE COUSIN(S)			

OTHER HISTORY

	Yes	No	Number	Last Use
Alcohol	☐	☐	_____ week	
Smoking	☐	☐	_____ day	
Vaping	☐	☐	_____ day	
Marijuana	☐	☐	_____ week	
Do you smoke anything other than Cigarettes??	☐	☐		List:
Recreational Drugs?	☐	☐		List

NEUROLOGICAL REVIEW OF SYSTEMS

Neurologic/Psychiatric	Yes	No	Eyes	Yes	No
Weakness:			Blurred Vision		
Loss of Feeling in part of body			Double Vision		
Difficulty Walking			Loss of Vision in one eye		
Tremor			Dizziness		
Fatigue			Ear Pain		
Fainting			Hearing Trouble		
Memory Difficulty			Tinnitus		
Trouble Concentrating			Trouble Breathing through nose		
Headaches			Sore Mouth		
Trouble Sleeping			Teeth Trouble		
Depression			Persistent Hoarseness		
Crying			Voice Changes		
Excess Worry			Swallowing Trouble		
Anxiety					
Change in Sweating					
Heart			**Bones/Joints**		
Chest Pain			Joint Pain		
Palpitations			Joint Swelling		
Leg Pain with Walking			Chronic Low Back Pain		
Ankle Swelling			Chronic Neck Pain		
Lungs			**Genitourinary**		
Daily Cough			Frequent urination		
Shortness of Breath			Painful urination		
Allergy/Immunology			Trouble starting urine		
Seasonal Allergies			Trouble holding urine		
Other Infections			Urinate more than twice a night		
			Blood in urine		
Lymphatic/Hematologic			**Men**		
Enlarged Glands			Erection issues		
Easy bruising or bleeding			Sexual issues		
Stomach			Discharge from penis		
Frequent nausea or vomiting			Testicular issue		
Vomiting Blood			**Women**		
Frequent Stomach Pain			Unusual vaginal bleeding		
Chronic Constipation			Discharge		
Chronic Diarrhea			**Breasts**		
Bowel Habit Change			Lump or Discharge of Breast		