Dr. Andrew Jervis

3-1153 Esquimalt Road, Victoria, BC, V9A 3N7 Phone: (778) 265-4305 Fax: (778) 265-4306

New Patient Intake Form

Name _____ Age: _____
Date of Birth (d/m/y) _____ Gender: M / F MSP # _____
Phone # _____ Alt. # _____
Address _____
_____
Emergency Contact _____ Ph. # _____

Dear Patient,

Welcome to my practice. Currently, I am a part-time practitioner with the plans to work 3.5 days per week. Our clinic offers a full-time walk-in clinic for more immediate concerns. I plan to continue part-time practice with the aim of gradually increasing my availability to full-time. Please be aware that my availability may be subject to change.

Our physicians and staff maintain an attitude of respect, which we kindly ask you to return.

It is important to identify myself as your family practitioner to others who may be involved with your care. This is so that important information regarding your health is communicated to me in a timely fashion.

Certain medications require extra care and monitoring. These include narcotics and other medications with a potential to develop dependency. Should you require these medications, you will be asked to agree to certain conditions before they are prescribed.

Unfortunately, I do not refill medications over the phone. If you are out of medication, this is because it is time for it to be re-evaluated.

CANCELLATION POLICY

Our office requires a minimum of 24 hours' notice if you need to cancel an appointment. If we are given less than 24-hours' notice, or if the appointment is missed, there will be a charge for the appointment, $40 for general appointment, $75 for physicals.

Please indicate below that you understand the above information and thus agree to enter into my practice.

Name (please print) _____ Date _____

Signature _____

Medical Questionnaire:

Please identify the name of your previous family doctor, and your reason for seeking a new physician:

_____

Please identify any medical conditions which currently affect you:

_____
_____
_____
_____
_____
_____
_____
_____

Please identify any previous surgical procedures, and indicate their reason and year:

Procedure: _____
Reason: _____
Year: _____

Procedure: _____
Reason: _____
Year: _____

Procedure: _____
Reason: _____
Year: _____

Others:

_____
_____

Please identify any previous admissions to hospital, and their year:

_____
_____
_____

PATIENT NAME:_____

Please identify any specialist physicians involved in your care:

_____
_____
_____
_____

Please identify any other practitioners involved with your care (example- physiotherapists, naturopathic doctors, chiropractor, etc.)

_____
_____
_____

Please identify any current or past Mental Health problems or conditions you have experienced or are experiencing presently (i.e.: PTSD, Post-Partum, Depression, Anxiety etc.):

_____
_____
_____
_____
_____
_____
_____
_____

Please identify all prescription medications, over the counter medications, herbal medications and vitamins that you take on a regular basis.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please identify any adverse reactions or allergies you have to medications or other substances.

_____
_____
_____
_____

Please describe your family history:

Mother:
Alive ____ Deceased ____ Medical illnesses:_____
_____
Father:
Alive ____ Deceased ____ Medical illnesses:_____
_____

Siblings and any major illnesses:
_____
_____
_____

Children, age, and any major illnesses:
_____
_____

In the extended family- any cancer, diabetes, heart disease, stroke or genetic conditions
_____
_____
_____

Do you smoke? If so, indicate when you started and how many per day:
_____

Have you tried to quit? If so, what methods have you tried:
_____

Please indicate which option below best describes your alcohol intake:

Never _____ Occasionally (example: holidays) _____
Less than 1 drink/week _____ 1-5 drinks/week _____
5-10 drinks/week _____ +10 drinks/week_____ Indicate amount _____

PATIENT NAME:_____

Do you sometimes drink >4 alcoholic drinks on one occasion? Y / N

In the past, did you ever consume alcohol more regularly than you do currently?

_____

Please indicate any current or past recreational drug use

_____

_____

Please indicate which option below best describes your exercise habits (outside of work):

Never _____ Less than 30 minutes per week _____ 30-60 minutes per week _____
1-2 hours per week _____ More than 3 hours per week _____

Briefly describe what activities you participate in for exercise:

_____

_____

Please indicate your current relationship status (all that apply)

Married ____ Common-law ____ Single ____ Widowed ___ Divorced ____
Other romantic relationship ____

Please indicate your sexual orientation:

_____

Please indicate your occupation:

_____

Please briefly describe any stressful life events that are currently impacting your mental or physical health:

_____

_____

_____

Please indicate the date of your last full physical exam:

_____

Please indicate the last date of the following screening procedures if applicable:

Pap smear _____ Mammogram _____ Colonoscopy _____

FIT test (stool test for colon cancer screening) _____

Please indicate the year of the following vaccinations if known:

Tetanus shot _____Flu shot _____ Zoster (shingles) shot _____
Pneumovax (pneumonia) shot _____ Cervarix / Gardasil _____
Other (please specify) _____

Women only:

Previous pregnancies _____
Previous births (indicate whether vaginal or caesarean) _____

Children only:

Vaccinations up to date: Y/N Prematurity: Y/N
Reaching developmental milestones: Y/N

Please indicate any other information you feel it is important for your doctor to know:

_____
_____
_____
_____

Thank you!!

Dr. Andrew Jervis

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Date:_____

Dear Dr._____
Ph:_____ Fax: _____

Re: Patient_____
Date of Birth_____
Address: _____
_____

The above patient has come under my care and I would greatly appreciate it if you could send me a COPY of the patient's medical records. Please send relevant and recent medical records that will assist in the care of this patient. Please do not send the whole chart. Consult and imaging reports are appreciated as well as chart summaries. Encounter notes and lab results are only useful if done within the last year.

Thank you very much for your prompt reply.
Kindest Regards,

_____

Dr. Andrew Jervis

I consent to the release of the above information to Dr. Andrew Jervis (68183), and I understand this service is NOT covered by my insurance. Upon receiving a bill, I agree to pay the requisitioned doctor a reasonable fee for this service.

Signed:_____ Date:_____

Please DO NOT SEND original documents. Esquimalt Medical Clinic has an entirely electronic medical record system (profile). Some, but not all, of the information you supply will be scanned into our computer record before shredding. Esquimalt Medical Clinic cannot accept any responsibility for `safe keeping` of any original medical documents or consequences and liabilities resulting from loss of original documents if they are sent to us.