L Mehdi
MEDICAL CLINIC

FANSHAWE MEDICAL CENTRE
Unit 201 - 215 Fanshawe Park Road West
London, Ontario N6G 5A9
Phone: 519-645-2444

Please note scheduling a Meet & Greet could take Several Months

- Patient LEGAL Name: Preferred Name(if applicable): _____
  - First:_____ Middle:_____ Last:_____
- DOB(DD/MM/YYYY):_____Age:_____Sex:_____
- Relationship Status:_____# of Household Members Applying:_____
- VALID Healthcard #:_____VersonCode:_____
- Full Address:_____
  - City: _____ Postal Code:_____
- Phone Number: [Preferred #: ☐ HOME ☐ CELL ☐ BUISNESS]
  - Home:_____Cell_____Buisness:_____
- Email Address (**IMPORTANT**):_____
- Prefered Pharmacy: _____
  - Address:_____
  - Phone Number:_____Fax:_____
- Previous Family Physician: ☐ Retired ☐ Still Practing ☐ None
  - Name: _____
  - Address:_____
  - Phone Number:_____Fax:_____
- Emergenecy Contact - Name:_____
  - Relationship to you:_____Phone:_____

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INCOMPLETE FORMS WILL NOT BE PROCESSED & SHREDDED APPROPRIATELY
NO STATUS UPDATES WILL BE PROVIDED & NO GAURENTEES ON ACCEPTANCE
[Please bring all your **Medications** and Immunization Records with you to your first appointment]

Fanshawe Family Medical Clinic

Please drop off a **completed** paper copy of this form and leave it with our receptionist during working business hours OR use the Locked Dropbox available on 2nd floor, beside our clinic, for processing and to be contacted by a member of our team to schedule a meet & greet. Please bring a **COPY** of your completed form to your first appointment for review by your physician. This form is designed to streamline your appointment and to reduce the likelihood that prominent issues are overlooked.

INCOMPLETE FORMS WILL NOT BE PROCESSED

- Patient Name:_____ Date of Birth: _____
- Partner/Spouse Name:_____ Country of Birth:_____
- Children/Siblings: (Please list names, gender, year of birth & any serious illnesses):
  - _____
  - _____
  - _____
  - _____
- Current Occupation:_____ Employer(Company)/School:_____

- Current/Ongoing Medical Conditions (E.g: High Blood Pressure, High Cholestrol, Diabetes, IBS, Depression, Anxiety, Osteoarthritis, Rheumatoid Arthritis, SLE, Sleep Terros, Insomnia, COPD, Osteoarthritis etc...):

_____

_____

_____

_____

- Previous/Resolved Medical Conditions (E.g: Childhood Asthma, Eczema etc...):

_____

_____

_____

_____

- Surgeries/Procedures/Hospitalizations (Please include the **YEAR** & detailed reason(s) of the hospitilzaiton and/or type of procedure)

_____

_____

_____

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- Patient Name:_____Date of Birth: _____

- Prescription Medications (Attach/List names of each medication, dose/strength and how often they are taken e.g: Lipitor 10mg once per day, ramipril 5mg two times per day):

_____

_____

_____

_____

- Over-The-Counter Medications (including Vitamins/Supplements) and Herbal Products (Attach/List names of each product, dose/strength and how often they are taken:

_____

_____

- Allergies (include the allergic trigger and the type of reaction when exposed, e.g: Penicillin – Rash, Peanuts-Hives):

_____

_____

- Dietary Prefrences (Vegentarian, Vegan, etc..): _____

- List the Name, Contact information and type of Specialist(s) involved in your care:

_____

_____

- Smoking History: [ ] Current Smoker(if yes, fill below) [ ] Ex-Smoker [ ] Never Smoked
  - Year you Quit (if applicable): _____
  - Average # of cigarettes per day:_____ # of Years Smoking:_____
- Alcohol History: [ ] Regular [ ] Socially/Rare [ ] Never
  - Type (eg: Liquor/Beer/Wine/Other:_____ # of drinks per week:_____
- History/Current use of recreational/IV drugs (Eg: Marijuana, CBD oil/gummies, Cocaine etc...):

_____

_____

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- Patient Name:_____Date of Birth: _____

- Family Medical History: (Please indicate **Blood** Relatives (Parents, Siblings Grandparents, Aunts and Uncles), **AGE** at which they were diagnosed and **Write/Circle** the corresponding condition):
  - Cardiovascular Disease (Heart Disease, Heart Attack, Heart Failure, etc...): ☐ NO ☐ YES
    Family Member(s), Condition & Age:_____
    _____
  - Neurological Disease (Stroke, TIA, Multiple Sclerosis, Parkinson's, etc...): ☐ NO ☐ YES
    Family Member(s), Condition & Age:_____
    _____
  - Endocrine Disease (High Blood Sugar (Diabetes Type 1 or Type 2), Cushings, Addisons, Thyroid Disease (hypothyroidism/ hyperthyroidism), etc...): ☐ NO ☐ YES
    Family Member(s), Condition & Age:_____
    _____
  - High Blood Pressure (Hypertension): ☐ NO ☐ YES
    Family Member(s), Condition & Age:_____
    _____
  - High Cholestrol (Dyslipidemia/Hyperlipidemia): ☐ NO ☐ YES
    Family Member(s), Condition & Age:_____
    _____
  - Rheumatological Conditions (Rheumatoid Arthritis, Gout, Systemic Lupus, etc...): ☐ NO ☐ YES
    Family Member(s), Condition & Age:_____
    _____
  - Mental Health Conditions (Anxiety, Depression, Bipolar, Schizophrenia, etc...): ☐ NO ☐ YES
    Family Member(s), Condition & Age:_____
    _____
  - Cancer (Thyroid, Lung, Breast, Liver, Ovarian, Cervical, Uterine, Colon, Prostate, Testicular, Skin (Melanoma), etc...) ☐ NO ☐ YES
    Family Member(s), Condition & Age:_____
    _____
    _____
  - Other Conditions: _____
    _____
    _____

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