Zen Medical
2424 St Johns St.
Port Moody, BC V3H 2B1
patients@zenmedcare.ca
www.zenmedcare.ca

New Patient Registration: Dr./NP. _____

Name:
First: _____ Middle: _____ Last: _____

Preferred Name: _____ Maiden/Previous: _____

PHN: _____ Date of Birth: _____/_____/_____
Day Month Year

☐ Female
☐ Male
☐ Other_____

Per MSP:
☐ Female
☐ Male
☐ Other_____

Pronouns: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Contact Information:

Home Phone: _____ Cell Phone: _____

Other Phone: _____ Email: _____

Second Contact Person/Next of Kin:

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First and Last Name: _____

Relationship to Next of Kin: _____

Phone: _____

Reason for switching/leaving previous family doctor: _____

_____

_____

_____

Patient Questionnaire

Previous Family Doctor / Nurse Practitioner (if any): _____

Medical and Mental Health History (if any):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Surgical History (if any, include date / year):

_____ _____

_____ _____

Medications (include any prescribed, over-the-counter such as vitamins/ supplements.

_____ _____

_____ _____

_____ _____

_____ _____

Allergies (include allergies to medications, food or environment/ seasonal)
(also include type of reaction – ie. anaphylaxis, hives, rash):

_____ _____

_____ _____

Health Screenings (if applicable):

Last Pap Test for Cervical Cancer Screening (25 years of age or above):

_____

Last Mammogram for Breast Cancer Screening (40 or 50 years of age or above):

_____

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Last FIT Test for Colon Cancer Screening (for 50 years of age or above):

_____

Family History (if known, include both medical and mental health conditions):

Mother: _____

Father: _____

Siblings: _____

Paternal Grandparents: _____

Maternal Grandparents: _____

Social History:

Language/s (if other than English): _____

Alcohol use:

Type of alcohol: _____

Consumption per week: _____

Tobacco use:

# of cigarettes/packs per day: _____

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# of years smoking: _____

Date you quit smoking (if ex smoker): _____

Drug use (specify and how often per week):

Type of drugs: _____

Consumption per week: _____

Occupation: _____

Physical Activity (type of activity and minutes per week): _____

_____

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Pharmanet:

Patient Consent to Access PharmaNet

The Province of British Columbia has established the provincial pharmacy network and database known as "PharmaNet" pursuant to section 37 of the Pharmacists, Pharmacy Operations and Drug Scheduling Act, R.S.B.C. 1996, c. 363, and which may be continued pursuant to section 13 of the Pharmacy Operations and Drugs Schedule Act, S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

Name of Patient: **Name of Physician:**

I, _____ , authorize _____

and persons directly supervised by him/her to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.

I understand that withdrawal of this consent must be in writing and delivered to the above-named physician.

Executed at _____, this _____ day of _____, 20 ____.

Signed and Delivered by:

Name of Patient: Patient Signature:

_____ _____

in the presence of:

Witness name: Witness (signature)

_____ _____

Date:

_____