Hilltop Medical Clinic

15331 16th Avenue, Surrey. B.C.
Pod 1,2,3,4 on 2nd Floor
Pod 5 on 1st Floor (through Rexall)

Phone: 604-531-5575

Please fill out all fields to the best of your ability and email completed form to forms@hilltopmedical.ca OR drop them off to Hilltop Medical Clinic. Once received we will contact your with a new patient appointment date & time.

Full Legal Name (as listed on Drivers License): _____

Preferred First Name : _____ Hilltop Family Doctor: _____

History Form - Date Completed: _____ Email: _____

Birthdate (DD/MM/YYYY): _____ PHN (Care Card) _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____

Gender: _____ Postal Code: _____

Height: _____ (indicate inches or cm) Weight: _____ (indicate LBS or KG)

Date of Height & Weight: _____ Preferred Pharmacy: _____

Current & Past Family Doctors: Please list all in order of most recent (and include the year you last saw each doctor):

1. _____ 3. _____
2. _____ 4. _____

Current & Past Medical Specialists: Please list all in order of most recent (and include the year you last saw each specialist):

1. _____ 3. _____
2. _____ 4. _____

Why are you currently looking for a new Family Doctor: _____

Do you currently have any open ICBC claims?: Y / N **Do you currently have any open WCB claims?:** Y / N

Current chronic (ongoing) concerns: (eg hypertension, diabetes, high cholesterol, fibromyalgia, arthritis etc)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____

Allergies/reactions to medications/substances:

1. _____ Type of reaction: _____
2. _____ Type of reaction: _____
3. _____ Type of reaction: _____

Past serious conditions / surgeries: (eg. heart attack, stroke, hysterectomy, bypass surgery etc) (attach a separate list for additional items)

1. _____ Date: _____ 5. _____ Date: _____
2. _____ Date: _____ 6. _____ Date: _____
3. _____ Date: _____ 7. _____ Date: _____
4. _____ Date: _____ 7. _____ Date: _____

Current medications: Including vitamins, minerals, herbals and over the counter (attach a separate list for additional items)

1. _____ Strength: _____ Dosage: _____ For: _____
2. _____ Strength: _____ Dosage: _____ For: _____
3. _____ Strength: _____ Dosage: _____ For: _____
4. _____ Strength: _____ Dosage: _____ For: _____
5. _____ Strength: _____ Dosage: _____ For: _____
6. _____ Strength: _____ Dosage: _____ For: _____

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Full Legal Name (as listed on Drivers License): _____

Preferred First Name : _____ Hilltop Family Doctor: _____

Family history: conditions/diseases present in first degree relatives:

Father: Age:_____ Deceased / Living Conditions: 1. _____ 2. _____ 3. _____

Mother: Age:_____ Deceased / Living Conditions: 1. _____ 2. _____ 3. _____

Brother: Age:_____ Deceased / Living Conditions: 1. _____ 2. _____ 3. _____

Brother: Age:_____ Deceased / Living Conditions: 1. _____ 2. _____ 3. _____

Sister: Age:_____ Deceased / Living Conditions: 1. _____ 2. _____ 3. _____

Sister: Age:_____ Deceased / Living Conditions: 1. _____ 2. _____ 3.

Personal social history *(circle or complete as required)*

Current Marital Status *(Circle Current Status Below)*

Married Common Law Divorced Single Widow/er # of Marriages:

Children:

# of sons_____	Years of Birth	1) _____	2) _____	3) _____	4) _____
	Health status	_____	_____	_____	_____
# of daughters_____	Years of Birth	1) _____	2) _____	3) _____	4) _____
	Health status	_____	_____	_____	_____

Children's last name if different than yours: _____

Test History: Include last year of test | Pap) _____ | Colonoscopy) _____ | Mammo) _____ | FIT) _____

Obstetrics:

# of pregnancies: Full Term _____ Miscarriage(s) _____ Abortion(s) _____

Year of pregnancies: Full Term _____ Miscarriage(s) _____ Abortion(s) _____

Occupation:

Present occupation: _____ For how long_____

Past occupations: 1._____ how long _____ 2._____ how long _____

Current Habits:

Smoking: Y / N For how long (# years): _____ # per day: _____ # per week: _____ Type_____

(Past Habits) Never Smoked: Y / N Quit **(year)** _____ Smoked for # of Years: _____

Alcohol: Y / N For how long (# years): _____ # per day: _____ # per week: _____ Type_____

(Past Habits) Never Drank Alchohol: Y / N Quit **(year)** _____ Smoked for # of Years: _____

Other Drugs Y / N	Marijuana Y / N	Cocaine Y / N	Heroin Y / N	Amphetamines Y / N
	Frequency: _____	Frequency: _____	Frequency: _____	Frequency: _____

Exercise:

1) Type: _____ Frequency: _____ 3) Type: _____ Frequency: _____

2) Type: _____ Frequency: _____ 4) Type: _____ Frequency: _____

Hobbies: _____

HILLTOP MEDICAL CLINIC

Suite 200 15331 – 16th Avenue, Surrey, B.C. V4A 0C1

Dr. A. Benitez-Gomez Dr. B. Tyrell Dr. A. Mazurek Dr. R. Thavarajah	Dr. J. Nolte Dr. F. O'Brien Dr. P. Mukheibir Dr. J. O'Brien Dr. M. Cooner	Dr. I. Amankwe Dr. E. Baasch Dr. P. Brar Dr. R. Balakrishna	Dr. L. Perold Dr. S. Tayebi Dr. E. Terekhova Dr. N Gill Dr. R. Sangha	Dr. N Darby Dr. L Darby Dr. N. Boudreau Hilltop Walk-In Clinic	Dr. Jane Wu Internal Medicine Dr. Tom Barnett Psychiatry Dr. Garry Palak Physiatry

Consent to Use Electronic Communication

Hilltop Medical Clinic and all practitioners at this location are offering to communicate using the following means of electronic communications:

Check all that you wish to give electronic consent for between you and Hilltop Medical:

☐ Email ☐ Text messaging ☐ Videoconferencing (VSee Desktop or Phone app) ☐ Accession / Aero Online & App booking

Patient name: _____ DOB: _____(mm/dd/yy)

Family Physician: _____ Cell phone: _____

Email address: _____

Home address: _____

Initial below	
	I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as other conditions that the Physician may impose on communications with the patients using the services.
	I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physicians staff using these services with a full understanding of the risk.
	I acknowledge that either the Physician or myself, at anytime, can withdraw the option of communication through the services upon providing written notice. Any questions I had regarding the electronic communication consent have been answered.

To Decline Consent, please initial _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Ministry of Health

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.

I, _____, authorize _____
Name of Patient (print) *Name of Physician (print)*

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)
)
)
_____)
Patient (print))
)
in the presence of:)
)
)
_____) _____
Witness (signature)) *Patient (signature)*
)
_____)
Witness (print))
)
_____)
(Dated))