Sina Medical & Aesthetics Clinic
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505 Smithe St., Vancouver, BC, V6B6H1
P: 604-336-7462 **F:** 604-336-7463 **E:** med@mysina.ca

Intake Form – New Patients

Thank you for choosing Sina Medical clinic. Please fill this intake form to the best of your knowledge and either drop it off at the front desk or email it back to us (med@mysina.ca).

*If you do not know the answer or may not apply to you, please leave the space blank. * fields are required.*

Last Name*:		**First Name*:**	
Personal health number (PHN) *:		**Birth date*:**	
Address*:			
Phone*:		**Email*:**	
Emergency number*:		**Emergency Name & relationship*:**	

Who is your family doctor at Sina Medical Clinic*?

MEDICAL CONCERNS & PROBLEMS (please explain your current condition) *:

MEDICAL HISTORY:

*CCPX**	*CDM**	*MH**	*PHRA**
☐ Heart disease	☐ Hypertension	☐ Depression	☐ Weight at risk
☐ Heart Failure/Attack	☐ Diabetes	☐ Anxiety	☐ Sedentary lifestyle
☐ Lung disease	☐ COPD	☐ Manic	☐ Smoking
☐ Asthma	☐ Heart failure	☐ ADD/ADHD	☐ Eating unhealthy
☐ Kidney disease		☐ Panic/fear	☐ Alcohol
☐ Liver disease			☐ Addictions
☐ Brain/Nerve condition			
☐ Stroke			

ALLERGIES: (To what? What reaction did you have?) *

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CURRENT MEDICATIONS/VITAMNIS:

Medication/Vitamin*	Dosage	Medication/Vitamin*	Dosage

SURGICAL HISTORY (Please specify year): *

SOCIAL & PERSONAL HISTORY: *

Do you smoke? ☐ YES or ☐ NO	How many packs/cig per day? ____How many years?_____
Do you drink alcohol? ☐ YES or ☐ NO	How many drinks per week?
Do you use recreational drugs ☐ YES or ☐ NO	What do you use?
Do you exercise? ☐ YES or ☐ NO	Type? How often?

DO YOU CURRENTLY RECEIVE ANY HELP FROM FAMILY/ OTHERS WITH THE DAILY ACTIVITIES LISTED BELOW? Please check all that apply to you

IADL	NIADL
☐ Meal preparation	☐ Mobility in bed
☐ Ordinary housework	☐ Transfer from chair or bed
☐ Managing finances	☐ Locomotion inside and outside the home
☐ Phone use	☐ Dressing upper and lower body
☐ Shopping	☐ Eating
☐ Transportation	☐ Toilet or bath use

FAMILY HISTORY (First and second-degree relatives): *

Condition	Relative	Note
☐ Osteoporosis		
☐ Heart disease		
☐ Lung disease		
☐ Breast cancer		
☐ Colon cancer		
☐ Prostate cancer		
☐ Other (specify)		

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PREVENTIONS & HEALTH MAINTENANCE (Please specify an estimated date)**:**

Exam type*	**Date**
Dental examination	
Eye examination	
Bone density	
Last Colonoscopy (camera inserted to see large intestine)	

VACCINATIONS (Please specify an estimated date)**:**

Vaccine type*	**Date**
Tetanus/Tdap booster	
Hepatitis A	
Hepatitis B	
Pneumovax	
Gardasil/Cervarix	
Other (specify)	

RECENT MEASUREMENTS:

Height*: cm	Weight*: kg
BMI:	Blood pressure: / mmHg
Temperature: °C	Pulse: bpm

WOMEN ONLY:

Mammography (breast imaging)	Date:
Last PAP smear (check for cervical cancer)	Date:
Menstrual cycle:	☐ regular / ☐ irregular
Pregnancy history: Been pregnant? ☐yes ☐ no	Any miscarriage/abortion? ☐yes ☐ no
Recent abnormal vaginal bleeding?	☐yes ☐ no
If postmenopausal, do you take hormones?	☐yes ☐ no

Terms & Conditions: *

1-I understand that one or two medical issues are usually discussed at each visit.

2-I understand that the deadline for cancelling an appointment is 24 hours before the appointment time and I need to pay a fee of $30 for each appointment that I missed to attend or did not cancel before the 24-hour deadline.

3-I confirm that I have read the *frequently asked questions* (FAQs) on the clinic's website (www.mysina.ca) before contacting Sina Medical for follow-ups or general questions.

4-I understand that my doctor or the staff at Sina Medical may need to reach me by phone, email or secure telehealth video-conferencing and I agree to share my information over the phone or internet as long as I know Sina Medical team keeps my information private and confidential.

5-I authorize my doctor or the staff at Sina Medical to access my Pharmanet medication profile, health registry demographics, and the diagnostic test history for the purpose of providing care and treatment to me.

By writing your full name (in capital letters) below, you consent that you filled out this form with accurate information about yourself and agree to notify your doctor or the staff at Sina Medical if there is a change in your medical history or the treatment plan. You also consent that you read and agreed to all the terms & conditions mentioned above.

Full Name: **Date:**