Kawartha North Family Health Team

email form

Last Name (as appears on Health Card) _____

First Name _____ Email address _____

Male ☐ Female ☐ Birthday (D/M/Y) _____ Current Dr./Nurse Practitioner ☐ Y ☐ N

If Yes, who? _____ Where? _____

Health Card # _____ Expiry _____

Mailing Address _____

_____ Postal Code _____

Home Phone _____ Cell Phone _____

May we leave a message about cancellations/closures, etc. on your phone? ☐ Y ☐ N

May we leave confidential messages about results, etc. on your phone? ☐ Y ☐ N

Employment status: Retired ☐ Employed ☐ Self-employed ☐ Unemployed ☐ Student ☐

Marital Status: Single ☐ Married / Common Law ☐ Widowed ☐ Separated / Divorced ☐

Do you smoke or use tobacco? ☐ Y ☐ N How many per day? _____

If no, did you ever smoke? ☐ Y ☐ N How long? _____ When did you quit? _____

Do you drink alcohol? ☐ Y ☐ N How many per week? _____

Medical History: (*please attach separate page if necessary)*

Illness, disease or condition	When was this diagnosed?

Box 129, Fenelon Falls, ON K0M 1N0 Tel: 705 887 3535 Fax: 705 887 3530 / Box 899, Bobcaygeon, ON K0M 1A0 Tel: 705 738 5575 Fax: 705 738 5681
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Kawartha North
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Medication(s): (*attach pharmacy printout if possible)*

Medication Name *e.g. Lipitor*	**Dose** *e.g. 20mg*	**How many** *e.g. 1 tablet*	**Frequency?** *e.g. once daily*

Vaccination History:

Type	**Month/Year**
Influenza (flu vaccine)	
Prevnar 13, Pneumovax (pneumonia vaccine)	
Tetanus	
Zostavax (Shingles vaccine)	
Other:	

Preventative care:

	Year
Pap / Cervical Cancer screening	
Mammogram	
Bone Density	
Prostate test	
Colonoscopy	
FOBT (take home stool sample test)	

Allergies _____ None ☐

Signature _____ Date _____

Please note, failure to complete this application in full may result in delays!

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