Family Practice Patient Intake and Consent Form

Highbury Medical Clinic

1345 Huron Street, Unit 4, London, Ontario, N5V 1R9

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info@kamvamedical.ca

Clinician Information

Dr. Saadiyah Rao

Dr. Rao's Office Phone: (226) 667-0627

Please complete the patient information and health history sections and review the consent statements below.

Consent for Release of Medical Records

I have chosen to attend the above physician as my primary care provider. I hereby give permission for the release of my pertinent medical records from my current or previous health care provider.

I understand that I am responsible for any fees charged by my previous provider for this service.

Consent for Use of Medical Images and AI Documentation

I consent to the use of clinical photographs taken during my medical care for documentation purposes in my medical chart. I also consent to the use of secure, AI-supported tools for medical note-taking, understanding that my information will be handled in accordance with privacy and confidentiality standards.

Roster Agreement

By signing below, you consent to being rostered to the above physician under the Ontario Health Insurance Plan (OHIP) Family Health Organization model. You agree to seek primary care from this clinic whenever possible.

Patient Signature	**Date**
Parent or Guardian Signature	**Date**
Physician Signature	**Date**
Witness Signature	**Date**

Patient Information

Legal last name | **Legal first name**

Middle name | **Preferred name**

Date of birth (yyyy/mm/dd) | **Age**

Gender: ☐ M ☐ F ☐ Other

Health card number | **Expiry date**

Phone number | **Email**

Address

City | **Postal code**

Occupation

Emergency Contact

Name

Relationship | **Phone**

Pharmacy Details

Preferred pharmacy name

Pharmacy address

Pharmacy phone and fax number

Care Providers and Family History

Patient name: _____ Date of birth: _____

Current or Previous Family Physician or Specialist

Family physician if any

Specialists currently seen

Address

Phone **Fax**

Family Health History

Please list family history of health conditions like heart disease, cancer, diabetes, asthma, and mental illnesses. For each condition, specify which family member has or had it (e.g., mother, father, sibling, or grandparent).

Health condition	Family member

Personal Medical History

Patient name: _____ Date of birth: _____

Check all that apply and add details where needed.

Cardiovascular and Endocrine

☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes

Respiratory

☐ Asthma ☐ COPD ☐ Other Lung Disease:

Gastrointestinal

☐ IBS ☐ IBD ☐ Other:

Musculoskeletal and Pain

☐ Arthritis ☐ Back Pain ☐ Chronic Pain ☐ Fibromyalgia ☐ Other:

Dermatologic

☐ Eczema ☐ Psoriasis ☐ Acne ☐ Other Skin Condition:

Neurological

☐ Seizures ☐ Neuropathic Pain ☐ Other:

Mental Health

☐ Depression ☐ Anxiety ☐ PTSD ☐ Bipolar Disorder ☐ Other:

Surgical and Hospitalization History

Allergies and Medications

Patient name: _____ Date of birth: _____

Medication Allergies Only:

(Include the reaction)

Other Allergies

Please list any allergies to foods, latex, insect stings, vaccines, or environmental allergens (e.g., pollen, dust, pets). Include the allergen and type of reaction.

☐ No Known Allergies (NKA)

Current Prescription Medications

Medication name	Dose	Frequency

Over the Counter Herbal and Supplements

Social History

Patient name: _____ Date of birth: _____

Smoking status: ☐ Never ☐ Past ☐ Current

Packs per day **Years**

Alcohol: ☐ Never ☐ Occasionally ☐ Regular

Drinks per week

Recreational substances

☐ None ☐ Cocaine ☐ Magic Mushroom ☐ LSD

☐ Ice (Crystal Meth)/Meth ☐ Opioids ☐ Other

Other substance details

Frequency and duration

Marijuana: ☐ Never ☐ Occasionally ☐ Regular

If used, check the method or methods:

☐ Smoking ☐ Vaping ☐ Edibles (gummies, food, etc.)

☐ Oils / Drops ☐ Other: _____

Years

Past Substance Use History

Have you previously used any substances that you no longer use?

☐ No ☐ Yes

If yes, include tobacco, alcohol, cannabis or other substances. Approximate dates are fine.

Substance	Amount / frequency	How long used	When stopped

Screenings and Health Concerns

Patient name: _____ Date of birth: _____

Preventive Health Screenings

Have you ever had any preventive health screening tests (e.g., FIT test, colonoscopy, cholesterol, diabetes screening, or bone density scan)?

☐ Yes ☐ No ☐ Not Sure

If yes, specify the test, approximate date, and result if known.

Test	Approximate date	Result if known

Obstetric and Gynecological History

For female patients, if applicable.

Pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: _____

Please check any tests you have had and provide the approximate date and result if known.

Screening test	Approximate date	Result if known
☐ Pap Smear / HPV Test		
☐ Mammogram		

☐ Never had any of the above screenings

Any history of abnormal screening results? ☐ No ☐ Yes

If yes please specify

Health Needs and Concerns

☐ Diabetes ☐ Hypertension ☐ High Cholesterol

☐ Thyroid Disorder ☐ Asthma/COPD

☐ Skin Conditions (e.g., eczema, acne, psoriasis, etc.)

☐ Chronic Pain ☐ Addiction/Substance Use Disorder

☐ Mental Health Conditions (e.g., anxiety, depression)

Briefly describe your main health concern(s):

Care Goals and Patient Expectations

Patient name: _____ Date of birth: _____

Focus of Care

Our clinic specializes in general family medicine with an interest in dermatology and preventive care.

Please indicate if you are seeking care for:

☐ Dermatological concern ☐ Routine primary care

☐ Ongoing chronic condition management ☐ Other

Other care needs

Patient Expectations

What are your main goals in joining this practice?

Do you anticipate requiring regular prescriptions for pain medication or controlled substances?

☐ Yes ☐ No

Do you currently have a pain management or addiction specialist?

☐ Yes ☐ No

If yes, please provide name and contact:

Do you currently have any limitations or circumstances that may affect your ability to work or attend appointments regularly?

☐ Yes ☐ No

If yes, specify the reason or program (e.g., ODSP, WSIB, etc.):

Are there any programs, supports, or benefits (e.g., workplace, insurance, or government) currently assisting you with your health or daily functioning?

☐ Yes ☐ No

If yes, specify the reason or program: