Alert! Did you check in with **Receptionist first?**

Spruce Care
MEDICAL CLINIC

Date: _____
Last Name: _____ First Name: _____ AB Health Card No.:_____
Address: _____City: _____Postal Code:_____
Date of Birth: _____ Male ___ Female ___ other_____ Family doctor:_____
Home Number: _____ Cell Phone: _____Work Number: _____
Emergency Contact Name: _____ Emergency Contact Phone: _____
Medication Allergy: _____ Other Allergies: _____
E-Mail: _____

Current Medical History:
Wt_____ lbs / Kg Height _____ Cm / Inches / Feet
High Blood Pressure_____ Heart Disease____ Depression____ Anxiety_____
Diabetes ____Type____ High Cholesterol_____ Kidney Disease_____
Cancer ____ Type_____ Asthma_____ COPD____ Obesity_____ Other:_____

List ALL medications, prescription, herbs, vitamins you're currently taking:

_____

_____

Past Surgeries/Procedures: Name ALL, including Year. Etc.: Wisdom teeth, Colonoscopy, Tonsil, Appendix…..

_____

Family History: ex> Cancer (Type), Hypertension, Depression, Diabetes….. PLEASE include WHO in family, Ex: Maternal/Paternal/grandparent/aunt/uncle….WHO????

_____

_____

_____

Social
Occupation? _____
Do you exercise: YES NO How many times a week?_____
Do you smoke: YES NO How many cigarettes a day?_____ How many years?_____ Years Quit?_____
Do you drink alcohol: YES No How many days per week? _____
Do you drink caffeine: YES NO How many times a day? _____
Do you use recreational drugs? YES NO What kind?_____ How Often?_____
Did you get the flu Vaccine this year? YES NO Want to get it Don't want