Dr. Kristjan Mytting, MD, CCFP - New Patient Intake Form

Patient Information

First Name: _____ Last Name: _____

Date of Birth(DD/MM/YYY): _____

Gender(leave blank if you prefer not to answer):_____

Home Address:

Street: _____

City: _____ Province: _____

Postal Code: _____

Email Address:_____

Phone Number(s):

Home: _____ Work: _____

Cell: _____

Marital Status: _____ Occupation: _____

Health Care Number (PHN): _____

Emergency Contact Information (2nd Optional)

First Name: _____ Last Name: _____

Relationship: _____

Phone Number(s):

Home: _____ Work: _____

Cell: _____

First Name: _____ Last Name: _____

Relationship: _____

Phone Number(s):

Home: _____ Work: _____

Cell: _____

Medical History

Please check the box if you currently suffer from or previously experienced any of these conditions/diseases:

- □ Type 2 diabetes
- □ Type 1 diabetes
- □ Hypertension (high blood pressure)
- □ High cholesterol
- □ Kidney impairment/Disease
- □ Angina (chest pain)
- □ Heart Attack (MI)
- □ Stroke
- □ Migraines
- □ Multiple Sclerosis
- □ Hearing impairment/loss
- □ Visual impairment/loss
- □ Gallstones
- □ Pancreatitis
- □ Diverticular disease/diverticulitis
- □ Crohn's disease or Ulcerative Colitis
- □ Celiac disease
- □ Asthma
- □ COPD
- □ Rheumatoid arthritis
- □ Osteoarthritis
- □ Thyroid Disease
- □ Seizures
- □ psychiatric illness
- □ Blood Clot (DVT/PE)
- □ Liver disease including cirrhosis

Please list any other diseases or conditions you suffer or have suffered from: _____

Please List any previous surgeries you have undergone including the approximate date/year: ____

Please list any medications you currently take including the dose and frequency: _____

Please list any medication allergies: _____

Which Pharmacy do you normal attend? _____

Do you smoke cigarettes? ☐ Yes ☐ No

If yes please provide the daily amount: _____

Do you smoke marijuana? ☐ Yes ☐ No

If yes please provide the daily amount: _____

How many alcoholic drinks do you consume in an average week: _____

Do you use or have previously used any other drugs or illicit substances? ☐ Yes ☐ No

If yes please put down the drug name as well as the current or previous use amount: _____

Family Medical History

Please provide your best knowledge of any medical conditions in your immediate family (this includes grandparents, parents, siblings and children): _____

Patient Acknowledgement and Signature

The Mcleod Medical Clinic and Dr. Kristjan Mytting seek to provide optimal care to all patients within the clinic while facilitating a professional and safe work and care environment for all. To this end we ask all patients to be on time to appointments to the best of their ability. Fees for missed appointments may be incurred dependent on the discretion of the clinic. In addition we ask all patients to be respectful to the clinic staff and fellow patients. Abusive language or behavior including shouting, using slurs or derogatory language or physical acts of violence will not be tolerated and may result in a patients discharge from the clinic dependent on the discretion of the clinic staff.

By signing below you acknowledge you have read and agree to the above.

Name (please print): _____

Signature:_____

Date(DD/MM/YYY): _____