Phone: (905) 553 - 4232
Fax: (905) 553-6232
email: cec@completeendocrinecare.com
website: completeendocrinecare.com

Complete Endocrine Care
Endocrinology • Diabetes • Metabolism • Weight Management

Patient Medical History Form

Sections with **RED** borders must be filled.

Name on Health Card:	______________________________	Preferred phone:	_________________________
Preferred name:	______________________________	Alternative phone:	_________________________
Date of birth:	______________________________	E-mail address:	_________________________

Social History:	Smoking/alcohol status:
Marital Status: ❑ Single ❑ Re-married ❑ Married ❑ Widowed ❑ Divorced ❑ Other: ________________ Children: ❑ None How many daughters? _____ How many sons? _____ Ethnic background? (optional) _________________ Birthplace? _______________ Year moved to Canada? _____________	Do you smoke cigarettes? ❑ Non-smoker ❑ Current smoker. How many packs per day? _____ What age did you start? _____ ❑ Ex-smoker. How many packs per day? _____ What age did you start? _____ What age do you quit? _____ Do you drink alcohol? ❑ Yes ❑ No If yes, what is the amount, frequency, and type? ____
Employment status:	**Health insurance:**
❑ Employed, occupation:__________________ ❑ Retired, previous occupation_____________ ❑ Unemployed ❑ Student: ______________________________ ❑ Other: ________________________________	❑ ODB ❑ ODSB ❑ Trillium ❑ Private, name: ____________________________ ❑ No insurance

Please list all current medications or supplements you are currently taking, or attach a list.

Name of Medication	Dosage (i.e. 500 mg)	Frequency (i.e. once daily)
/	/	
/	/	
/	/	
/	/	

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Medical History:	**Family History:**
Check all that apply ❑ Diabetes, year diagnosed: ______________ ❑ High blood pressure, year diagnosed: _____________ ❑ Coronary artery disease, year diagnosed: _________ ❑ Heart attack, year: _________ ❑ Stroke, year: _________ ❑ Cancer, type, year: _______________ Please list any other health problems not included above: ____ ____ ____ ____ ____ ____	Check all that apply ❑ Diabetes, relationship: _________________ ❑ High blood pressure, relationship: ________________ ❑ Coronary artery disease relationship: _____________ ❑ Heart attack, relationship: _____________ ❑ Stroke, relationship: _____________ ❑ Cancer, relationship, type: ______________________ Please list any other health problems not included above: ____ ____ ____ ____ ____ ____

Surgical History:	
Check all that apply ❑ Tonsils removed, year: ______________ ❑ Appendix removed, year: _____________ ❑ Gallbladder removed, year: ____________ ❑ Heart bypass surgery, year: ___________	Please list any other surgeries not included: ____ ____ ____ ____

Please list your current physicians:

Family Doctor: ____

Name	Speciality
	/
	/
	/
	/

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Please list any allergies you have:

____

____

Please provide the name and address of your preferred pharmacy:

____

____

Any additional information you wish to add:

____

____

____

____

____

____

- ☐ I consent to receiving correspondence, such as requisitions via email from Complete Endocrine Care. I understand that this is not legally considered a confidential method of communication and I am aware that options such as faxing and picking up forms in person from the clinic are available to me.

*** **Please join Medeo, which is secure messaging used by the office to send requisitions and sensitive data. Also, the details of your future appointments are there for your review.**

- ☐ I understand that there may be a fee associated with missed appointments. This includes a $30 no show fee for dietitians and a $50 fee if more then one appointment is missed with Dr. Qureshy. Fees can be avoided by cancelling or rescheduling AT LEAST 24 hours before the scheduled appointment. *** The fee rates are subject to change according to office policy.

- ☐ I understand samples are a privilege, not a right. We have a ZERO tolerance policy on abuse towards office staff and any violation of this can lead to an immediate suspension of receiving further samples. If I do not select this box, I am declining the privilege of receiving samples.

Signature: ____________________________________ Date:________________________________

(type your name)

Thank you for taking the time to complete this form