ELM Medicine

Unit 4- 1521 Upper Ottawa Street
Hamilton, Ontario L8W 3J4

Phone: 905-318-3006
Fax: 833-268-3660
info.elmmedicine@gmail.com
www.elmmedicine.ca

Specialist Clinic. Internal Medicine. Infectious Diseases. Hepatitis B & C. Chronic Pain. Lifestyle Medicine Clinic. Stress Reduction Clinic
Dr. Atreyi Mukherji, MD, MPH, FRCPC

PATIENT INTAKE PACKAGE: HEPATITIS B/C

Please complete the following documents in the package. All documents are required to be completed, before consultation.

1. Health Questionnaire
2. No Show Policy

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HEALTH QUESTIONNAIRE: HEPATITIS B/C

PATIENT INFORMATION - PLEASE COMPLETE		
Patient's Last Name: First: ❒ Mr. ❒ Mrs. ❒ Ms.		
Home Address:	City:	Postal Code:
Email Address:	Home Phone:	Mobile Phone:
Date of Birth:	OHIP Number:	

1. What is your preferred method of contact by the office?

_____

2. What is your goal for the visit?

_____

_____

_____

3. List all medications that you are currently taking, either by prescription or over the counter. Please also bring a list or bottles of your medications, during the first office visit.

_____

_____

_____

_____

_____

4. List all vitamins and supplements that you are currently taking, either by prescription or over the counter.

_____

_____

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5. List any allergies to medications or other items.

_____

6. List all health problems that you have been diagnosed with, by a medical doctor.

_____

_____

_____

7. List all prior surgeries.

_____

_____

_____

8. PREVENTATIVE HEALTH	**(YES OR NO)**
Pap smear (women) in last 3 years:	
Mammogram in last 2 years:	
Colonoscopy or Stool check for Colon Cancer:	
Dental check up in last year:	
Influenza Vaccine:	
Pneumonia vaccine:	
Hepatitis A and or B Vaccine:	
Tetanus Vaccine:	
BCG Vaccine:	

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9. List any health problems in your immediate family (parents, grandparents, siblings, children)

_____

_____

_____

10. SOCIAL HISTORY

Marital status: _____

Children: _____

Drug benefits: _____

11. <u>Lifestyle (YES OR NO AND EXPLAIN)</u>

- **Current or past tobacco use:** _____
- **Current or past Cannabis use:** _____
- **Current or past use alcohol use:** _____
- **Current or past IV drug use:** _____
- **Any other recreational drug use:** _____
- **Immigrant or Refugee to Canada:** _____

Patient Signature: _____

Date: _____

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NO SHOW POLICY

PATIENT NAME:_____ DATE OF BIRTH: _____

In order to serve you better, we want you to be aware of our clinic policy for scheduled appointments.

PLEASE INITIAL BESIDE EACH STATEMENT:

_____ We understand that sometimes you cannot make your appointment. It is your responsibility to notify our clinic if you cannot make the appointment, for any reason.

_____ Please cancel or reschedule your appointment during our regular clinic hours (Tuesday-Thursday) and a minimum of 2 business days prior to your appointment.

_____ NO SHOW: If you do not attend an appointment and do not contact the clinic to cancel within 2 business days, you will be charged a no show fee of $35 + HST.

_____ Changes made by us to your appointment: If we have changed your appointment and you fail to receive the message or you did not confirm the new appointment date, you will not be charged a fee.

_____ Arriving late for an appointment: We will do our best to accommodate you if you arrive late for your appointment. This may mean that you have to wait for the next available opening. If we cannot accommodate you, we will need to reschedule your appointment.

_____ You agree to provide up to date contact information to our receptionist.

_____ You agree to provide a valid email address, so we can email you health related education resources, or other communications.

Self-reschedule of appointments on-line for follow up appointments, may be accessible in some cases. The same policy for rescheduling and no show apply.

Please sign below that you have read and understand these policies.

Patient Signature: _____

Date: _____