721 Front Road South
Amherstburg ON N9V 0B4
Phone: 519-736-7770

Please read carefully prior to completing the accompanying questionnaire

At the Amherstburg Family Health Team (AFHT) we are pleased to offer an integrated approach to your health care needs. Working together with you, our team of physicians, nurses, nurse practitioners, dietitian, social worker and respiratory educator provide comprehensive care for your health.

Your first step to becoming a patient involves filling out the attached questionnaire. To understand your healthcare needs fully, we ask that you provide us with **complete** personal health information as part of your application. **This includes a complete listing of all your medications and a pharmacy printout list.**

Dr. Grant Fortowsky is accepting new patients starting October 2020. Please be aware of the following:

- Priority of patient intake will be given to those without a current family physician, seniors, and those with chronic diseases. Our office will call you to schedule an initial intake appointment with Dr. Fortowsky.
- Dr. Fortowsky will be working part-time, averaging three days a week. By agreeing to be a patient at AFHT, you commit to seeing other physicians and nurse practitioners in Dr. Fortowsky's absence, including at our after-hour access before seeking care at another walk-in clinic.
- **Please bring all your medications** to the initial intake appointment and all future appointments. Please regularly keep track of your medication refills, as appointments are required for medication refills unless exceptional circumstances arise.
- Dr. Fortowsky does not prescribe opioids (narcotics) as first line treatment for chronic pain.
- Dr. Fortowsky requires all patients on controlled substances to sign a Controlled Substances Contract.
- Missed appointment without prior cancellation may be subject to a fee.
- Dr. Fortowsky does not complete disability paperwork until you have been a patient for at least six months, and he has known you well.

Our phones are very busy, so we respectfully ask that you **DO NOT CALL OR EMAIL OUR OFFICE TO ASK THE STATUS OF YOUR INTAKE**. We will get back to with your initial appointment.

The Amherstburg Family Health Team
721 Front Road South Unit #101
Amherstburg, ON N9V 2M4
519-736-7770

NEW Patient Intake Form

Thank you for your interest in being a patient at The Amherstburg Family Health Team.
Please fill in the information below the best you can and return it to our office at the address above

General Patient Information

Please complete the following fields as they appear on your health card. If you need help filing this form out please contact 519-736-7770 ext
Please print as neatly as possible so that we receive your information accurately.

Last Name:	**First Name:**
Date of Birth:	**Health Card #:** **Version:**
Mailing Address:	
City:	**Province:**
Postal Code:	
Home Phone Number	**Mobile/Cellphone Number**
Alternative phone number:	**Which # would you like us to reach you at first?** ☐ Home Number ☐ Mobile/ Cellphone ☐ Alternative Number

Gender:
☐ Female ☐ Intersex ☐ Male ☐ Trans (female to male) ☐ Trans (male to female) ☐ Two Spirit ☐ I prefer not to answer ☐ Other

Email address

We provide the option of virtual care (online booking, secure patient messaging, video visits) through Medeo Health. By providing us your e-mail you will be sent an invitation to Medeo Health to have access to the virtual care features we offer.

Email Address:

____________________ @ ______________

Please note: We ensure that there is an equal opportunity for access and care whether you are signed up for virtual care or not. You're care will not be impacted in anyway if you do not have access to virtual care.

I do not have access to: ☐ Internet ☐ A Computer ☐ A Smartphone

Do you require your care to be provided in a specific language other than English?

☐ NO ☐ YES (please specify which language)

Power of Attorney/Substitute Decision Maker

The following questions pertain to the person you have chosen to make decisions on your behalf if you are unable to do so yourself. Someone who you would like to be contacted in the case of an emergency and knows your wishes for care.

Last Name: **First Name:**

Relation: ☐ Spouse ☐ Child ☐ Parent ☐ Other (please specify)

Phone Number:

Alternative Phone Number:

Previous Healthcare Provider

Current/Previous Family Physician Name: **Phone Number:**

Reason for finding a new family physician:

Pharmacy Information

Pharmacy Name:

Pharmacy Address:

Pharmacy Phone Number:

List of current medications, including dosage and reason for taking including any vitamins or minerals you are taking (*Please ask your pharmacy to print out a medication profile list and attach it to this form before returning it to us

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Allergies

What you are allergic to?	What was the reaction?

Any urgent health issues? (Example: had a recent heart attack; recently diagnosed with cancer, etc.)

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Family History

Any family history of cancer?

☐ NO ☐ YES (please describe below)

Type of Cancer	Relationship to you	Age they were diagnosed

Any family history of cardiovascular disease (heart problem or stroke?) in your immediate family (parents, siblings, children)?

☐ NO ☐ YES (please describe below)

Illness description	Relationship to you	Age they started with the illness

Any other family health history?

____

Social History

Marital Status

☐ Married ☐ Single ☐ Common-Law ☐ Separated ☐ Widowed ☐ Other (Please specify):

Occupation:

☐ Full Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Other (Please Specify):

Smoking Status ☐ Non-Smoker (Never smoked)	☐ Current Smoker	☐ Ex-Smoker
	Age when you started smoking:	Age when you started smoking:
	Packs per day:	When did you quit?
	Would you like help to quit? ☐ YES ☐ NO	
Alcohol Use? ☐ No	☐ Yes	
	Approximately how many drinks/week?	
Marijuana Use? ☐ No	☐ Yes	☐ Smoke ☐ Edible ☐ Vape
	How often?	
Other Substance Use? ☐ No	☐ Yes	Would you like help quitting? ☐ No ☐ Yes
	Which Substance(s)?	
	How often do you use?	
Caffeine ☐ No	☐ Yes ☐ Coffee ☐ Tea ☐ Pop/ Soda	How many drinks/day?

Previous Surgeries (specify type of surgery, approximate year, name of surgeon/where it was done)

☐ NO ☐ YES (please describe below)

Type of Surgery	Approximate Year	Name of Surgeon	Where was it done?

Past Medical History (please provide as much detail as possible, especially year of onset)

Problem	NO	YES	Year	Details
Cardiovascular Disease				
Heart Attack	☐	☐		
Stent	☐	☐		
Bypass	☐	☐		
Heart Failure	☐	☐		
Stroke/TIA (mini stroke)	☐	☐		
Peripheral Vascular Disease	☐	☐		
Other:	☐	☐		
Cardiovascular Risk Factors				
High Blood Pressure	☐	☐		
High Cholesterol	☐	☐		
Diabetes	☐	☐		
Obesity	☐	☐		
Kidney Disease	☐	☐		
Respiratory Disease				
COPD/ Emphysema	☐	☐		
Asthma	☐	☐		
Sleep Apnea	☐	☐		
Other:	☐	☐		

Problem	NO	YES	Year	Details
Digestive Issues				
Heartburn	☐	☐		
Stomach infection	☐	☐		
Stomach ulcer	☐	☐		
Crohn's/Colitis	☐	☐		
Irritable Bowel Syndrome	☐	☐		
Constipation	☐	☐		
Diverticulitis	☐	☐		
Hemorrhoids	☐	☐		
Liver issues	☐	☐		
History of stomach bleed	☐	☐		
Other:	☐	☐		
Blood Issues				
Anemia	☐	☐		
Blood clot	☐	☐		
Other:	☐	☐		
Thyroid Issues	☐	☐		
Urinary Issues	☐	☐		
Gynecological Issues	☐	☐		
Muscle & Bone Issues				
Arthritis	☐	☐		
Back pain	☐	☐		
Osteoporosis	☐	☐		
Chronic Pain	☐	☐		
Fibromyalgia	☐	☐		
Gout	☐	☐		
Other:	☐	☐		

Problem	NO	YES	Year	Details
Neurological Issues				
Dementia	☐	☐		
Parkinson 's disease	☐	☐		
Tremors	☐	☐		
Seizures	☐	☐		
Other:	☐	☐		
Vision issues	☐	☐		
Hearing issues	☐	☐		
Skin issues	☐	☐		
Dental issues	☐	☐		
Mental Health				
Depression	☐	☐		
Anxiety	☐	☐		
Bipolar	☐	☐		
Addictions	☐	☐		
Other:	☐	☐		
Personal history of Cancer	☐	☐		
Any Other Health Concerns	☐	☐		

Previous Hospitalizations of Importance (when, where, for what?)

Date of Hospitalization	Where?	For what reason?

Specialists that you are currently seeing or have seen recently (name, reason for seeing, when last seen)

Name of Specialist	Reason for seeing them	Last time you saw them

Preventive Health Questionnaires (if applicable)

Previous mammogram? (when was last one? Any abnormal ones previously?)

Previous colonoscopy? (When was last one, done by who, any abnormal results?)

Previous fecal occult screening for colorectal cancer? (when was it last done?)

Previous pap test (when was last one, any abnormal tests in past?)

Previous bone mineral density (when and where was last one done?)

Previous vaccines and which year (tetanus? Pneumonia vaccine? Shingles vaccine? Flu shot?)

Previous disability claims OR work-place injury claims with details? Any unresolved claims?

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Thank you for your interest in the Amherstburg Family Health Team.

I have read and understood the accompanying letter. I certify that the above information is true and complete to the best of my knowledge; failure to disclose pertinent information OR purposefully disclosing false information will make the application to this practice null and void.

Signature____________________ Date________________