Village Pharmacy LAKEFIELD LTD

Patient Intake Form **Date:**

Personal Information	
Name:	Date of Birth:
Address Street: City: Postal Code: Email:	Tel Home: Tel Cell: Health Card Number: Family Physician/NP: Prescription Drug Coverage: Yes ☐ No ☐
Health Information	
Medical Allergies:	Environmental Allergies:
Medical Conditions - select all that apply:	

- ❑ Migraines/Headaches
- ❑ Depression
- ❑ Anxiety
- ❑ Alzheimer's/Memory Impairment
- ❑ Seizure Disorder
- ❑ Parkinson's Disease
- ❑ Ears, nose, throat condition

  _____
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Seasonal Allergies
- ❑ Asthma
- ❑ COPD
- ❑ Thyroid Disorder
- ❑ Heart Disease
  - ❑ Atrial Fibrillation
  - ❑ Arrhythmia
  - ❑ Coronary Artery Disease
  - ❑ Heart Failure
  - ❑ History of Heart Attack
  - ❑ High Blood Pressure
  - ❑ High Cholesterol
- ❑ History of Stroke
- ❑ Gastroesophageal Reflux Disease (GERD)
- ❑ Irritable Bowel Disease
- ❑ Inflammatory Bowel Disease
- ❑ Chronic Diarrhea or Constipation
- ❑ Liver Disease
  - ❑ Liver function? _____
- ❑ Kidney Disease
  - ❑ Kidney function? _____
- ❑ Diabetes
  - ❑ A1C? _____
- ❑ Osteoporosis/osteopenia
- ❑ Pain
  - ❑ Type: _____
- ❑ Arthritis
  - ❑ Rheumatoid Arthritis
  - ❑ Osteoarthritis
- ❑ Other Rheumatoid/Autoimmune Conditions:

  _____
- ❑ Cancer: _____

Vaccine History - select all that apply	Medication History - please list all medications you take, including OTC, NHPS/herbals
☐ Seasonal Influenza Date: _____ ☐ Pneumonia Vaccine Date: _____ ☐ Shingles Vaccine Date: _____ ☐ HPV Vaccine (eg gardasil) Date: _____ Other: _____	

Social Information	
Smoking Status:	Cannabis use:
Alcohol intake: (# drinks/week)	

Other Information: