MATAWA HEALTH
CO-OPERATIVE

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Matawa Health Co-operative Patient Application Form

Last Name:	First Name:	Preferred Name:
Date of Birth:	Health Card Number:	First Nation (If Applicable):
Gender:	Phone Number/ E-mail:	Status Number:
Address:		Language:
Name and Address of Previous Health Care Provider:		
Pharmacy Name:	Pharmacy Address:	
Next of Kin/Legal Guardian (Name):	Relationship:	Phone Number:
Emergency Contact Name (If different from above):	Phone Number:	Relationship:

Allergies

☐ None
☐ Allergies to Medication:
☐ Food Allergies:

Cardiac

☐ None ☐ Arrhythmia ☐ Cardiomyopathy ☐ Congenital ☐ High Blood Pressure
☐ Angina ☐ Atrial Fibrillation ☐ Congestive Heart Failure ☐ Heart Attack ☐ Pacemaker
☐ Other:

Surgery/ Procedures

☐ None	Surgery/ Procedure	Date

Current Medications- Prescription/ Non-Prescription/ Over the Counter

Medication (Dose or Strength)	Reason for Taking	Times Per Day

Specialists Seen

Name	Date	Reason For Visit

Medical Problems

☐ None
☐ Arthritis
Specify:
☐ Asthma
☐ Blood Disorder
Specify:
☐ Cancer:
Specify:
☐ COPD/Emphysema:
☐ Diabetes
Type 1, Type 2, Prediabetes
☐ Gastrointestinal
Specify:
☐ Gynecological
Specify:

☐ Headaches
☐ Hepatitis
Specify:
☐ High Cholesterol:
☐ HIV +
☐ Hypertension:
☐ Kidney Disease/Dialysis
Specify:
☐ Mental Health
Specify:
☐ Pain
Specify:
☐ Paralysis
Specify:
☐ Seizures
Specify:

☐ Skin Condition
Specify:
☐ Stroke/ TIA
Date:
☐ Substance Abuse
Specify:
☐ Thyroid
Specify:
☐ Trouble Hearing
☐ Tuberculosis
☐ Visually Impaired
☐ Other:

Lifestyle

Smoking	Yes ☐	Total Years Smoked: _____	# Cigarettes per Day: _____
	No ☐		
	Quit ☐	Previous, # of years: _____	Year quit: _____
Alcohol	Yes ☐	# of drinks/ Weeks _____	
	No ☐		
Recreational Drug Use	Yes ☐	List:	
	No ☐		
Marital Status:	Single ☐	Married/ Common Law ☐	Widow/Widower ☐ Children #:
Education:	Last Year of School Completed:		Currently a student: Yes ☐ No ☐
Place of Employment:			
Type of Employment:			
Retired:	Yes ☐	Year:	No ☐

Family History

Do you have a family history of disease, i.e. parents or siblings with heart disease, stroke, high blood pressure,diabetes, cancer, high cholesterol, etc. Please list relationship and disease:

Family Member	Disease	Age of Onset	Alive or Deceased

Results

Date of your last:

Physical Check up _____

Blood Work _____

Pap Test _____ Normal ☐ Abnormal ☐

Bone Density _____ Normal ☐ Abnormal ☐

Mammogram _____ Normal ☐ Abnormal ☐

Colon Cancer Screening: FOBT (Stool Sample Test) _____ Normal ☐ Abnormal ☐

Colonoscopy _____ Normal ☐ Abnormal ☐

Prostate Specific Antigen Blood Test _____ Normal ☐ Abnormal ☐

Immunization Record

Up to date: Yes ☐ No ☐ Don't Know ☐

Date of Last Tetanus: _____ Date of Last Flu Vaccine: _____

Date of Pneumonia Vaccine: _____ Shingles Vaccine: _____

Upon acceptance to Matawa Health Cooperative and booking of New Client Intake appointment. Do you consent to the review of medical records available through Electronic Record Systems. Some examples are Diagnostic reports (x-ray, ultrasounds), Labs, such as blood work, Doctor/ Specialist notes.

Yes ☐ No ☐

**** All information is kept confidential and is used only for health-related purposes*****

**** The initial appointment is for introductions and gathering information about your health care needs. Forms such as WSIB, ODSP, Special Diets, etc. will not completed at this time ****

By signing below, I consent that, I have read and understand the information above and have provided to the best of my knowledge correct up to date information.

Signature: _____ Date: _____