Muskoka Community Health Hub:

Port Carling Site

Patient Information

Health Card # ______________________ **Version Code:** __________ **Exp:** ____________

Surname: ______________________ **First&Middle Name:** ______________________

Gender: ______________________ **Date of Birth:** ______________________

Mailing Address: ______________________ City/Town: ______________________

Province/State: __________ Postal Code/Zip Code: __________ Country: __________

Home Phone: ______________________ Cell Phone: ______________________

Cottage Phone: ______________________

Email Address: ____

Family Doctor: ______________________ Location: ______________________

Pharmacy: ______________________ Smoker: Y N

Allergies: ____

Emergency Contact: ______________________ Relationship: ______________________

Home Phone: ______________ Cell: ______________ Work: ______________

Medical Condition(s):

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____

Surgeries: ____

Medications (including over the counter and herbal supplements):

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Health Maintenance:

Last Physical: ______________________ PAP: ______________________

Mammogram: ______________________ Bone Mineral Density: ______________________

Colon Cancer Screen: ______________________ Prostate Screen: ______________________