General Intake Form

Please complete the following information and return this form to MediGuide in the provided envelope. Feel free to attach an additional sheets needed.

Member Information

Last Name _____ First Name _____

Date of Birth _____ Gender _Female _Male

Street Address _____

City _____ Province _____ Postal Code _____

Daytime Phone _____ Alternate Phone _____

Email _____

Father'sFull Name _____ Mother's Maiden Name _____

Diagnosis Information

_____

General Intake Form Details

Current Plan of Care	
Allergies	
Family History	
Past Medical History	
Symptoms	
History of Present Illness	
Primary Member Request	

Social History

Height		Weight		BMI	
Martial Status					
Alcohol	_Yes _No				
Tobacco	_Yes _No				
		PPD		Year Smoked	

Treating Physician Information

(Physician treating you for this condition)

Name _____ Specialty _____

Medical Center _____

Phone _____ Fax _____

Street Address _____

City _____ Province _____

Other Physicians

List any other physicians that have been involved in your care for this diagnosis. Attach additional sheets as needed.)

Name _____ Specialty _____

Medical Center _____

Phone _____ Fax _____

Street Address _____

City _____ Province _____

Diagnostic Tests

If known, where did you have your biopsy, radiology, or other tests performed?)

Lab _____

Type of Test _____ Location _____

Phone _____ Fax _____

Lab _____

Type of Test _____ Location _____

Phone _____ Fax _____

Medication List

List all prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements ,etc)

Medication Name	**Dose** *(mg , units , drops)*	**When Taken** *(daily , bedtime , etc)*	**Reason for Taking** *(blood pressure , diabetes , ect)*

What are the questions you would like to ask the World Leading Medical Center?