Sudbury District Nurse Practitioner Clinics
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30 Ste. Anne Road, 3rd Floor
Sudbury, ON P3C 5E1
P: 705-671-1661
F: 705-671-0177

623 Main Street
Lively, ON P3Y 1M9
P: 705-692-1667
F: 705-692-0177

100-200 Larch Street
Sudbury, ON P3E 1C5
P: 705-673-3721
F: 705-805-3660

Welcome to the Sudbury District Nurse Practitioner Clinics

Patient Registration Form – ADULT (18+)

Thank you for your interest in the Sudbury District Nurse Practitioner Clinics (SDNPC) and for filling out this application completely. If you are applying for a child (aged 0-17yrs) you will need to request a child intake form. Upon completion of this form, a nurse practitioner will review your information and invite you for a face to face visit to determine if your needs can be met at this clinic. All applications are assessed and prioritized by the Executive Director. We *aim* to schedule these visits within 6-12 months of application. In the case of a lengthy waiting list to access an intake appointment at their requested site, patients may be offered to become a patient at a different site than the site requested on the intake form.

Please note, incomplete forms will not be processed. Do not attach any medical records to your application other than the ones requested in this application (i.e. medication list, immunizations).

**Please note, we are not able to refill any medications including narcotics, or address any of your medical concerns until after you have been accepted as a registered patient and formally enrolled in our primary care clinic. If you have any urgent concerns, please seek care at Health Sciences North or a walk-in-clinic. **

Once accepted, patients are registered to the clinic and while they usually see one provider on a regular basis, they may be required to see alternate providers from time to time.

Sudbury District Nurse Practitioner Clinics has a Code of Conduct that sets boundaries for acceptable behaviour within our clinic. Acts of physical or verbal violence are not tolerated and may result in termination of services or discharge from the clinic.

I have read and understand this. **Please initial in the box** ☐ **DATE:** _____

Name (*Last, First*): _____

Preferred Site*: Lively ☐ Sudbury: St. Anne Site ☐ 200 Larch St. Site ☐

*Depends on capacity at that site; you may be offered a provider at a different location.

Who Is Completing This Form: Self ☐ Partner ☐ Family Member ☐ Other: _____

If a family member is applying with you, please indicate name to ensure booking with same provider: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name (If Different from Legal Name): _____

Sex assigned at Birth: Male ☐ Female ☐

Gender Identity: Male☐ Female☐ Transgender☐ Two Spirit ☐ Non-Binary☐ Questioning ☐ No Answer ☐

Pronouns: He/Him☐ She/Her☐ They/Them ☐ Other: _____

Date of Birth (YYYY/MM/DD): _____OHIP Number: _____ Version Code: ____

OHIP Expiry Date (YYYY/MM/DD): _____ Check Box If You Do Not Have an OHIP # ☐

Preferred Language:_____ Is a translator required? Yes☐ No ☐ If so, specify: _____

Address: _____ Apartment/Unit Number: _____ P.O Box _____

Town/City: _____ Prov: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Preferred Method of Contact: Home ☐ Cell ☐ Work ☐ Email ☐

Emergency Contact Name _____ Relationship to You _____

Emergency Contact Phone # _____

Name & Location of Previous Provider * _____

You will be required to de-roster from your provider if accepted to this clinic

Reason for Leaving: _____

Are You Registered with Health Care Connect? * Yes ☐ No ☐

You will be required to remove your name from Health Care Connect if accepted to this clinic

Preferred Lab Location? LifeLabs: Larch ☐ Lasalle ☐ Long Lake Rd ☐ Other _____

Immunizations

*Please indicate if you have been vaccinated against the following and provide date of last dose if known; OR provide a copy of immunization records/yellow card

Measles, Mumps, Rubella: Y ☐ N ☐	Pneumonia: Y ☐ N ☐	TB skin test: Y ☐ N ☐
Tetanus, Diphtheria: Y ☐ N ☐	HPV: Y ☐ N ☐	Other:
Pertussis/Whooping cough Y ☐ N ☐	Hepatitis A: Y ☐ N ☐	Other:
Covid 19: Y ☐ N ☐	Hepatitis B: Y ☐ N ☐	Other:
Influenza/Flu: Y ☐ N ☐	Shingles: Y ☐ N ☐	Other:

Personal Medical History (Please Check Any That Apply)

	Condition	Year Diagnosed		Condition	Year Diagnosed
☐	Angina				
☐	Heart Attack/MI		☐	Hepatitis (A/B/C)	
☐	High Blood Pressure		☐	Liver Disease (fatty liver etc)	
☐	High Cholesterol		☐	Kidney Disease	
☐	Atrial Fibrillation		☐	Obesity	
☐	Congestive Heart Failure		☐	Diabetes (Type 1 ☐ Type 2 ☐)	
☐	Peripheral Vascular Disease		☐	Thyroid (Hypo ☐ Hyper ☐)	
☐	Sleep Apnea		☐	Chickenpox	
☐	Asthma		☐	Anxiety	
☐	COPD/Emphysema		☐	Depression	
☐	Stroke		☐	Anorexia/Bulimia	
☐	Seizures		☐	ADHD/ADD	
☐	Migraine		☐	Bipolar Disorder	
☐	Bell's Palsy		☐	Schizophrenia	
☐	Blood Clots		☐	PTSD	
☐	Anemia		☐	Prostate Issues	
☐	Lupus		☐	Sexually Transmitted Disease	
☐	Osteoarthritis		☐	HIV	
☐	Osteoporosis		☐	Drug Addiction	
☐	Acid Reflux		☐	Alcoholism	
☐	Stomach Ulcer		☐	Eczema/Psoriasis	
☐	Diverticulosis		☐	Cancer/Type:	
☐	Chronic Pain		☐	Other:	
			☐	Other:	

Have You Had Any Past Injuries/Fractures? Include Year

Have You Had Any Past Surgeries? Include Year

Reproductive Medical History

Menstrual Periods	Age at Onset _____ Age When Stopped _____	**Not Applicable** ☐
Pregnancy	# of Pregnancies _____ # of Live Births _____ # of Abortions _____ # of Miscarriages _____	**Not Applicable** ☐
Method of Delivery	Vaginal ☐ C-Section ☐	**Not Applicable** ☐
Fertility Treatments?	Yes ☐ No ☐	**Not Applicable** ☐
Plan to Have More Children?	Yes ☐ When? _____ No ☐	**Not Applicable** ☐
Method of Birth Control	Birth Control Pills ☐ IUD ☐ Condoms ☐ Tubal ☐ Vasectomy ☐ Abstinence ☐ Other? _____	**Not Applicable** ☐

Family Health History

Family Member	**Living (L) Deceased (D) Unknown (U)**	**Medical Condition** (Examples; Diabetes Mellitus, Cancer & Type; High Blood Pressure; Heart Attack; Stroke, etc. Please Include Age at Diagnosis If Known)
Mother		
Father		
Mother's Mom		
Mother's Dad		
Father's Mom		
Father's Dad		
Sister		
Brother		

Medications & Supplements

Please contact your pharmacy and request an ACTIVE medication list printout and attach it to this form. Please list any prescription medications, vitamins/supplements or "over the counter" medication you take regularly and as needed. Please include eye drops, injections, patches, creams, lotions etc.

Medication Name *i.e. Tylenol/ Acetaminophen*	**Dose/Amount** *i.e. 500mg, 2tabs*	**How Often** *i.e. Twice Daily or As Needed (PRN)*	**Time of Day** *i.e. AM/Breakfast, Noon, PM/Supper, Bedtime*	**Reason For Taking** *i.e. Back Pain*	**Missed Doses** *i.e. Never, # of times per week, per month*

Which Pharmacy Do You Use? (Name, Location, Phone #) _____

What Best Describes Your Prescription Drug Coverage? (Check All That Apply)

None ☐ NIHB, Veterans Affairs, other Federal ☐ Seniors Drug Plan (ODB) ☐

Trillium ☐ ODSP ☐ OHIP+ (24yrs & Under) ☐ WSIB ☐ Other ☐ _____

Private Insurance (i.e./Sunlife, Manulife, etc. through past/present employer) ☐ _____

Do you find it difficult to afford the out of pocket cost of your medications? Yes ☐ No ☐

Do You Have Any Allergies/Intolerances? Yes ☐ No ☐ Allergy Testing Done? Yes ☐ No ☐

If Yes Please List Allergen and Reaction Below: (Please Include Medication, Latex, Environmental)

Allergen: _____ Reaction: _____

Allergen: _____ Reaction: _____

Allergen: _____ Reaction: _____

Lifestyle/Social

Highest Education:	**Employment:**	**Housing Status:**	**Transportation:**
Grade 8 ☐ Grade 12 ☐ College ☐ University ☐ Postgraduate☐ Current Student ☐ Other: _____	FT ☐ PT☐ Unemployed ☐ Occupation: _____ Ontario Works ☐ ODSP/Disability ☐ Retired ☐ Child/Student ☐ Other: _____	Live Independently ☐ Retirement Home ☐ Assisted Living ☐ Homeless Shelter ☐ Geared to Income ☐ Other: _____	Drive Own Car ☐ Bus/Taxi ☐ Handi-Transit ☐ Bike ☐ Walk ☐ Family/Caregiver ☐ Other: _____

PHYSICAL ACTIVITY: Do you accumulate at least 150 minutes of moderate to vigorous aerobic activity per week (ie/ 30mins 5x/wk)? Yes ☐ No ☐ Sometimes ☐
Do you participate in muscle strengthening activities using major muscle groups at least twice a week? Yes ☐ No ☐ Sometimes ☐

SLEEP: Are you getting 7 to 9 hours of good-quality sleep on a regular basis, with consistent bed and wake-up times? Yes ☐ No ☐ Sometimes ☐

NUTRITION: Do you follow a special diet (ie. Vegan etc)? Please specify: _____

CAFFEINE INTAKE: Coffee ☐ Tea ☐ Cola ☐ Energy Drinks ☐ None ☐
How many? _____ per day/week/month (circle as appropriate)

ALCOHOL: (i.e. 12 oz Beer/1.5 oz Shot of 40% Liquor/5 oz Wine = 1 Standard Drink)
How many? _____ per day/week/month (circle as appropriate)

SMOKING STATUS: Do/did you smoke Cigarettes? (circle as appropriate)
Year Started ____ Year Quit ____ How Many? ____ per day/week/month (circle as appropriate)
Do/did you smoke a pipe/marijuana/vape/use chewing tobacco? (circle as appropriate)
Year Started ____ Year Quit ____ How Many? ____ per day/week/month (circle as appropriate)

RECREATIONAL DRUG USE: Yes ☐No ☐ Product Used _____

Screening Tests

Year of Last	Year	Result	
PAP		Normal ☐	Abnormal ☐
Mammogram		Normal ☐	Abnormal ☐
Bone Density		Normal ☐	Abnormal ☐
FOBT/FIT		Normal ☐	Abnormal ☐
PSA (Prostate Bloodwork)		Normal ☐	Abnormal ☐
DRE (Digital Rectal Exam)		Normal ☐	Abnormal ☐
Colonoscopy		Normal ☐	Abnormal ☐
Lung Cancer Screening CT		Normal ☐	Abnormal ☐

Additional Health Care Providers

Specialty	Yes	No	Reason	Date of Last Visit
Dentist	☐	☐		
Optometrist	☐	☐		
Physiotherapy	☐	☐		
Massage Therapy	☐	☐		
Chiropractor	☐	☐		
Naturopath	☐	☐		
Chiropodist	☐	☐		
Osteopath	☐	☐		
Dietitian	☐	☐		
Social Worker	☐	☐		
Psychologist	☐	☐		
Case Manager	☐	☐		
Support Worker	☐	☐		
Home Care	☐	☐		
Other:				

Do you currently see a specialist (i.e. Cardiologist, Ophthalmologist, etc.) for any health issues? Yes ☐ No ☐

Name: _____ Reason: _____ Date of Last Visit: _____

Name: _____ Reason: _____ Date of Last Visit: _____

Name: _____ Reason: _____ Date of Last Visit: _____

Any Other Information You Think Is Important for Us to Know: _____

How Did You Hear About Us? _____

I confirm the information I have provided in this form to be complete, truthful and accurate.

_____ _____

Signature Date (YYYY/MM/DD)