GEM CLINIC PATIENT INTAKE QUESTIONNAIRE

PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT

Your appointment is with:

☐ Dr. J. Rahman ☐ Dr. K. Zuñiga ☐ Dr. N. Ríos ☐ Dr. S. Kogan ☐ Dr. T. Buffie

Patient Information (please circle where needed):

First Name:	Last Name:	Preferred Name:
Street Address: City: Postal Code:		Home: Cell: Work:
Date of Birth:	PHIN (9 digits):	MB Health:
Sex/Gender: male female other:		Occupation:
Email:		
Treaty Number:	Band:	
Emergency contact person:	Relationship:	Ph:
How do you want to receive electronic reminders? I don't, thanks email text		

Family Doctor:

Name:	Address:
City:	Postal Code:

Optometrist: **Pharmacy:**

Name:	Name:
Location:	Location:

Other Doctor/Specialist (to correspond with):

Name:
Location:
Phone:
Type of Doctor/Specialist:

Height: _____ cm **Weight: _____ kg**

What is your eye issue? _____

Attach a printout of medications from your pharmacy or use the following:

Eye Drops	Frequency	Eye (Left/Right)
for example: Xalatan	*1 x at night*	*both*

Medications	Dosage	Frequency
for example: Metformin	*500 mg*	*2 x a day*

Allergies	Reaction	Treatment

Eye Surgeries	Operated Eye	Month/Year	Surgeon	Lens (if cataract)

Medical conditions:

Surgeries within the last 10 years	Date	Surgeon or Hospital

Please Circle Yes or No and answer the questions below:

Do you have Home Care?	Yes	No
Name of Home Care case coordinator or nurse: Cell:		
Do you have a medical Health Directive or Power of Attorney? If Yes, please provide document(s) for us to see at registration.	Yes	No
Do you have Handi-Transit?	Yes	No
Do you smoke?	Yes	No
Do you wear contact lenses?	Yes	No
Do you drive?	Yes	No
Do you have a family history of glaucoma? If Yes, who?	Yes	No
Do you have a family history of macular degeneration? If Yes, who?	Yes	No

Patient Name: _____ DOB: _____