



MANGO Medical Clinic

4392 Beresford St, Burnaby V5H 0E7 | T: 778-379-4392 | F: 778-379-4391 | www.mangomedical.ca

Form B: Adult Health History Form

Date:

Your answers on this form will be kept confidential, and they will help your healthcare provider get an accurate history of your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Thank you!

A: DEMOGRAPHIC:

Last name	
First name	
Date of birth	
Gender	
Address	
City and Postal Code	
Personal Health Number (PHN)	
Primary phone	
Secondary phone	
Email	
Emergency contact name	
Emergency contact number	

6. What allergies do you have?

7. Have you had the following tests? If so, when?

- Stool test for blood (FIT) No Yes, date: _____
- Colonoscopy No Yes, date: _____
- Mammograms* No Yes, date: _____
- Pap smears* No Yes, date: _____

*applies to female patients

Please comment on any abnormal results:

C: FAMILY HISTORY:

Do you have any family history of

- heart attack No Yes, who: _____
- diabetes No Yes, who: _____
- stroke No Yes, who: _____
- hip fractures No Yes, who: _____
- breast cancer No Yes, who: _____
- colon cancer No Yes, who: _____
- other cancers No Yes, who: _____
- thyroid problems No Yes, who: _____
- rheumatological issues No Yes, who: _____
- hepatitis No Yes, who: _____
- anxiety No Yes, who: _____
- depression No Yes, who: _____
- bipolar No Yes, who: _____
- schizophrenia No Yes, who: _____
- suicide No Yes, who: _____
- alcohol or substance abuse No Yes, who: _____
- Other significant medical issues in your family:

D: MENTAL HEALTH SCREENING:

1. In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things? No Yes
2. Feeling down, depressed or hopeless? No Yes
3. Anxious, keyed up, or on edge? No Yes

E: SUBSTANCE USE HISTORY:

1. Do you smoke? No Yes, _____ packs a day for _____ years
 I quit in _____ (year) after smoking for _____ years
2. How many alcoholic beverages do you drink in a week? _____ drinks

3. Do you use recreational substances? No Yes

F: SOCIAL HISTORY:

1. Occupation (or prior occupation): _____
2. Are you: retired/ unemployed/ leave of absence/ disabled/ other:
3. Years of education or highest degree: _____
4. Are you on any forms of disability?
5. Do you have third party drug coverage?
6. Marital status (circle one): single, partner, married, divorced, widowed, other:

7. Who lives at home with you?
8. Do you have dietary restrictions?
9. Are you vegetarian?
10. Do you consider yourself to have a sedentary lifestyle?
11. Do you have any family members in our clinic? Who are they?
(If yes, please provide their full legal names and relationship to you)
12. Do you have any ongoing WorkSafeBC claims?
Yes No
If Yes, Claim No.: Date of Injury:
13. Do you have any ongoing ICBC claims?
Yes No
If Yes, Claim No.: Date of Accident:

Do you have anything else you would like us to know about you?



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FORM A: Clinic Policy

Providing the best possible medical care to our patients is our foremost priority. In order to serve all of our patients optimally, we follow a set of clinic policies in compliance of the standard of practice in this province.

We ask that all of our patients respect our policies and we encourage everyone to ask us questions they may have regarding these policies.

* Please read the following Clinic Policy carefully and initial each item. If you have any questions, please let us know before signing.

* As a patient at Mango Medical Clinic, you are entitled to some important Patient Rights. Please visit: www.mangomedical.ca/PatientRights for details.

Patient Attachment:

- I agree to attach to _____ as my primary care provider and:
(Doctor/NP's Full Legal Name)
 - Seek my health care from the Mango Medical Clinic whenever possible.
 - Identify my doctor or nurse practitioner (NP) in Mango Medical Clinic as my primary care provider when I visit any other health care provider.
 - Not have another family doctor as a regular doctor.
 - Communicate with my doctor or NP honestly and openly.
 - Respect Mango Clinic staff and refrain from any form of verbal or physical aggression or harassment.

Consent to Transfer Charts

- I understand that to provide adequate care to me, my primary care provider needs accurate and complete information of my existing medical files. I hereby give consent to my doctor or NP to request for medical files, chart, and documents from hospitals, clinics, laboratories, and other health care facilities that are necessary for taking care of my medical needs. I will inform my doctor or NP should there be any exceptions to the above.

_____ Clinic appointment bookings:

- A typical visit is scheduled for 10-15 minutes, depending on the type of visit.
- I understand that my doctor or NP might run behind on their schedule.
- Whenever possible, I will inform the clinic of the reason(s) of my visit so that the clinic can budget time appropriately.
- Longer appointment for complete physicals or procedures will be booked at the doctor or NP's discretion.
- I acknowledge that if I have multiple issues, my doctor or NP may prioritize them in the allotted time and may schedule follow up visits to go through my issues thoroughly.

_____ Childhood Immunizations:

- I acknowledge that Mango Medical Clinic may not be stocked with routine childhood immunizations for children under 6 years old. In this situation, I will contact the closest public health unit for these immunizations.

_____ Opioids, Sedatives and other controlled substances:

- I have read, and agree to the following:
 - There is insufficient clinical evidence that long term, escalating doses of opioid treatment is beneficial for chronic, non-cancer pain. Inappropriate use of opioid medications can lead to more harm than good. For the best quality of care, patients at Mango Medical Clinic will adhere to the Opioid Treatment Agreement before starting opioid therapy.
 - The College of Physicians and Surgeons of BC has a formal policy statement forbidding the concurrent use of Opioids and Sedative medications, and my doctor or NP is legally obliged to stop one or more of these medications with a taper.
 - Some parts of the Opioid Treatment Agreement includes: opioid medications must be prescribed to patients by a single physician only. Patients on opioid medications are subject to PharmaNet Checks and Random Drug Screening. The doctor or NP has the right to terminate opioid prescribing for the patient if any item of the Agreement has been breached.
 - Patients are allowed to view the Opioid Treatment Agreement upon request.

Uninsured services

- I understand that some services are not covered by the provincial Medical Services Plan. I have the right to know the Mango Clinic service fees before agreeing to the treatment.
- Common uninsured services include:
 - Sick notes and medical certificates,
 - Chart transfers,
 - Missed Appointments,
 - Insurance Reports,
 - Cosmetic procedures,
 - Driver's Physicals
 - Cryotherapy for non-plantar warts in adults,
 - Flu shots for patients not in high risk group ,
 - Private injections,
 - Medical legal letters and opinions,
 - Medical CPP Examinations and Forms,
 - After hours telephone advice.
- If an outstanding account has been incurred by me, payment is expected upon arrival at the next appointment. Dependent upon the type of appointment, Mango Medical Clinic may not be able to schedule future appointments until the balance has been paid.

Late or missed appointments:

- As appointments are in high demand, a 24 hours' notice is required to cancel appointments. This notification allows Mango Medical Clinic to offer available time to other patients needing care.
- If I am late for my appointment and my doctor or NP has to see the next patient, the clinic will try to fit me in at a later time slot. If I am unable to be seen due to my lateness, it is considered a missed appointment.
- Missed appointments are subject to a fee as recommended by Doctors of BC. Payment is expected before rescheduling.

Ending the therapeutic relationship:

- A positive therapeutic relationship relies on mutual trust and respect between the patient and the doctor or NP. If this foundation is lost, a productive therapeutic relationship may no longer be possible, and either the patient or the doctor or NP may choose to terminate this doctor-patient relationship.
- Mango Medical Clinic will provide resources where I may be able to find another physician.
- After ending the therapeutic relationship, I have the right to seek care from the clinic for up to 1 month for emergency reasons.
- If the reason for terminating the care relationship involves verbal or physical aggression towards any clinic staff, the grace period will not apply due to workplace anti-harassment legislation.
- It is within my right to at any time end the therapeutic relationship and transfer my care to another clinic. A chart transfer fee will be applicable.

_____ PharmaNet search:

- I consent to the doctor, NP or an Allied Health Professional (such as a nurse or pharmacist) in the clinic checking my prescription records in BC on my PharmaNet profile where all my recent prescription medications are documented.

_____ Receiving Email Communications

- I consent to receiving clinic notices by email, such as for Flu Clinics, appointment notices, screening test reminders, and clinic updates. I understand and accept that there is a small inherent risk to email communication such as unauthorized access. Emails from Mango Medical Clinic may contain medical information such as test results or specialist reports.

_____ General Communications

- I consent to communicate with Mango Medical Clinic including doctors, NP, nurses, clinic managers and medical office assistants via phone, text, email, mail, fax and other communication platforms.

_____ Medical Learners

- Mango Clinic doctors may provide medical education for residents or medical students in the clinic. My doctor will ask for my consent to see a medical learner before I see them.
- The medical learner will always review my encounter with one of the clinic doctors, and I can also ask to see the clinic doctor after seeing the learner.
- I will always have the choice of declining to see a medical learner, and this will not affect my medical care with the Mango Medical Clinic in any way.

By signing below, you indicate that you have had an opportunity to discuss the clinic rules, you understand and agree to the rules.

signature

Print name: _____

Date: _____



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Mango Medical Clinic Consent to Transfer of Medical Records

To:

Former Doctor/Clinic:

Fax number:

Phone number:

Re:

Patient's Name:

Date of Birth:

Personal Health Number:

New Doctor:

In the future, I/we will be attending the above medical office. In order to maintain continuity of care for myself (and my family members) please forward, at your earliest convenience, a copy of my entire chart to the above address (DO NOT FAX Records). Please use only one-sided photocopies, or if possible send records as a PDF file on a disk. THE ORIGINAL RECORD SHOULD NOT BE SENT, in keeping with the policy of the College of Physicians and Surgeons of BC.

I understand that you may charge a fee for this service and that this fee is not covered by my medical plan. Please bill me for any service fee. Thank you.

Patient or Guardian Signature:

Dated:
