

# Quadra Island Medical Clinic



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Box 340, Quathiaski Cove  
Quadra Island BC V0P1N0  
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## New Patient Form

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

PHN: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Okay to contact via email? Y / N

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Location: \_\_\_\_\_

Current Medical Conditions:

Current medication:

Allergies:

Family Medical History:

Past operations:

Cigarette Smoking history: Y / N    How long: \_\_\_\_\_ How many per day: \_\_\_\_\_  
Quit?: \_\_\_\_\_