New Patient registration form

Patient Information

Last Name:	Given Names:		
Date of Birth: dd / mm / yyyy	Age:	Health Card:	VC:

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ Other: ______________________

Sex: ❒ Male ❒ Female ❒ Other: ______________

A message regarding my health can be left on my voice mail or to contact person ❒Yes ❒No

Street Address:	City, postal code:
Home Phone:	Cell Phone:

Work, Education Information

Occupation:	Employer:
Do you receive welfare/FBA/pension/none/other? If yes please circle.	
Employer Address(optional):	
Highest Level of education:	Work Phone:

Emergency Contact

Contact Person:	Relationship to Patient:
Contact Phone #1:	Contact Phone #2:

Personal Medical History

Medical History
- ❒ High Cholesterol
- ❒ High Blood Pressure
- ❒ Diabetes
- ❒ Heart Attack / Heart Disease / Heart Failure
- ❒ Asthma or Chronic Lung Disease
- ❒ Seizures
- ❒ Osteoporosis
- ❒ Arthritis, Gout, or Joint Injuries
- ❒ Depression, Anxiety or Mental Health Issues
- ❒ Bone Fractures
- ❒ Other: ___________________________________

Cancer
- ❒ Breast ❒ Colon/Bowel ❒ Prostate
- ❒ Lung ❒ Other _______________________

Surgical or Procedure History
- ❒ Tonsils/Adenoids When? ___________
- ❒ Appendix When? ___________
- ❒ Bowel Surgery When? ___________
- ❒ Joint Replacement When? ___________
  Details ______________________________
  ____
- ❒ Colonoscopy When? ___________
- ❒ Upper Endoscopy When? ___________
- ❒ Cosmetic Surgery When? ___________
  Details ______________________________
  ____
- ❒ Wisdom Teeth When? ___________
- ❒ Other: ________________________________
  When? ______________________________

For Women Only

# of pregnancies:	# miscarriages/abortions:	# of children:
Date of Last Pap smear:	Date of Last Mammogram:	

Medications			
Please list all medications, including non-prescription drugs and herbals.			
Medication	Strength/Dose	# Tablets/Dose	How often
Pharmacy:		Location:	

Allergies	
Please list all drug, food, and environmental allergies.	
Allergy	Type of Reaction (e.g., rash, breathing problems, etc.)

Habits
Smoking Status: ❒ Never Smoked ❒ Currently Smoke: How many packs per day? ___________ For how many years? _________ ❒ Quit Smoking: When did you quit? ___________ For how long did you smoke? _________
Alcohol Consumption: How many drinks per week? ______________
Recreational drug use:

Family History					
Medical Condition	Relative(s) with condition	Age when diagnosed	Medical Condition	Relative(s) with condition	Age when diagnosed
High Blood Pressure			Colon/Bowel Cancer		
Heart Disease			Breast Cancer		
Stroke			Arthritis		
Diabetes			Depression		
High Cholesterol			Bipolar Disorder		
Asthma			Schizophrenia		
Other Cancers (provide details):					
Other Conditions (provide details):					

I confirm that above information are correct to the best of my knowledge.

Patient signature…………………………………………………… Date:……………………………………..