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	Surgical or Procedure History
❒ High Cholesterol	❒ Tonsils/Adenoids When? _____
❒ High Blood Pressure	❒ Appendix When? _____
❒ Diabetes	❒ Bowel Surgery When? _____
❒ Heart Attack / Heart Disease / Heart Failure	❒ Joint Replacement When? _____
❒ Asthma or Chronic Lung Disease	Details _____
❒ Seizures	_____
❒ Osteoporosis	❒ Colonoscopy When? _____
❒ Arthritis, Gout, or Joint Injuries	❒ Upper Endoscopy When? _____
❒ Depression, Anxiety or Mental Health Issues	❒ Cosmetic Surgery When? _____
❒ Bone Fractures	Details _____
❒ Other: _____	_____
Cancer	❒ Wisdom Teeth When? _____
❒ Breast ❒ Colon/Bowel ❒ Prostate	❒ Other: _____
❒ Lung ❒ 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:……..