



New Patient Registration

Name: _____ Date of Birth: _____

Female Male Marital Status: Single Married Divorced Other Same Sex Partner

Phone #: _____ Cell Phone #: _____

Health Card #: _____ Version Code: _____ Expiry Date: _____

Street Address: _____ City: _____ Postal Code: _____

Occupation: _____ Work Phone #: _____

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

DO YOU CURRENTLY HAVE A FAMILY PHYSICIAN? YES NO IF YES, WHO & WHY ARE YOU LEAVING?

Medical History <input type="radio"/> None	Date of Last Physical Examination: _____
<input type="radio"/> High Cholesterol/Fat	<input type="radio"/> Asthma
<input type="radio"/> High Blood Pressure	<input type="radio"/> Stroke
<input type="radio"/> High Blood Sugar (Diabetes)	<input type="radio"/> Seizures
<input type="radio"/> Heart Disease (Heart Attack, Arrhythmia)	<input type="radio"/> Arthritis
<input type="radio"/> Thyroid Disease	<input type="radio"/> Mental Illness (Bipolar, Schizophrenia, etc.)
<input type="radio"/> Depression/Anxiety	<input type="radio"/> Other
<input type="radio"/> Cancer	<input type="radio"/> Osteoporosis
<input type="radio"/> Bowel/Colon	
<input type="radio"/> Breast	
<input type="radio"/> Other _____	

Allergies:

Medications <input type="radio"/> None	
Name: _____ Dose: _____	Name: _____ Dose: _____
Name: _____ Dose: _____	Name: _____ Dose: _____
Name: _____ Dose: _____	Name: _____ Dose: _____
Name: _____ Dose: _____	Name: _____ Dose: _____
Name: _____ Dose: _____	Name: _____ Dose: _____

Name: _____

HABITS

Do you smoke? Yes No
How many cigarettes/day? _____
For how many years? _____
If you've quit, when? _____ & how long did you smoke? _____

Alcohol Consumption? Yes No If yes, how many drinks/week? _____

Recreational drug use? Yes No If yes, which drugs & how often? _____

WOMEN ONLY

Of pregnancies _____ # of miscarriages/abortions _____ # of living children _____

Date of last Pap test _____ Any previous abnormal results? Yes No

Date of last mammogram _____ Any previous abnormal results? Yes No

Hospitalizations & Surgeries (tonsils, appendix, etc.)

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

FAMILY HISTORY

High Blood Pressure Who: _____ Age: _____

Heart attack/heart disease Who: _____ Age: _____

Diabetes (High Blood Sugar) Who: _____ Age: _____

Cancer Colon/Bowel Who: _____ Age: _____

Breast Cancer Who: _____ Age: _____

other Cancers What kind? _____ Who: _____

Stroke Who: _____ Age: _____

Asthma Who: _____ Age: _____

High Cholesterol Who: _____ Age: _____

Mental Illness What kind? _____ Who: _____