New Patient Registration

Name: _____ **Date of Birth**: _____

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

Phone #: _____ **Cell Phone #**_____ **Email:** _____

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

Street Address: _____ **City**: _____ **Postal Code**: _____

Occupation: _____**Work Phone #** _____

Emergency Contact: _____ Phone # _____

Relationship to Patient: _____

Medical History

O None Date of Last Physical Examination: _____

O High Cholesterol/Fat
O High Blood Pressure
O High Blood Sugar (Diabetes)
O Heart Disease (Heart Attack, Arrhythmia)
O Thyroid Disease
O Depression/Anxiety
O Cancer O Bowel/Colon O Breast O Other _____
O Asthma
O Stroke
O Seizures
O Arthritis
O Mental Illness (Bipolar, Schizophrenia, etc.)
O Other
O Osteoporosis

Allergies:

_____

_____

Medications

O None

Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____

Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____

HABITS

Do you smoke? Yes O No O

How many cigarettes/day? _____

WOMEN ONLY

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

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

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

Hospitalizations & Surgeries (tonsils, appendix, etc.)

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

FAMILY HISTORY

O High Blood Pressure Who: _____ Age: _____

O Heart attack/heart disease Who: _____ Age: _____

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

O Cancer O Colon/Bowel Who: _____ Age: _____

O Breast Cancer Who: _____ Age: _____

O other Cancers What kind?_____ Who: _____

O Stroke Who: _____ Age: _____

O Asthma Who: _____ Age: _____

O High Cholesterol Who: _____ Age: _____

O Mental Illness What kind? _____ Who: _____