Patient Registration – Contact Information

Name: First: _____ Middle: _____ Last: _____

Preferred Name: _____ Maiden/Previous: _____

Date of Birth: ____/____/____ Sex: Female / Male
Day Month Year

OHIP #: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer: _____

Preferred Phone (select one): Home Cell Work Other: _____

E-mail (Optional – Appointment reminders and other notifications): _____

Emergency Contact
First and Last name: _____ Phone: _____

Relationship to emergency contact: _____

Immediate Family (living at same address): **Enter ONLY if family is or will be a patient here.**

Name: _____ Date of Birth: _____ OHIP: _____

Name: _____ Date of Birth: _____ OHIP: _____

Name: _____ Date of Birth: _____ OHIP: _____

Name: _____ Date of Birth: _____ OHIP: _____

Do you currently have a Family Doctor? Yes / No

Preferred Pharmacy Name: _____

Pharmacy Address: _____

HEALTH QUESTIONNAIRE

The purpose of this questionnaire is to ensure that your electronic medical record contains complete and up to date information so we can provide you with optimal comprehensive care. Please fill in the relevant sections to the best of your ability and give to your health care provider at your next visit. Strict confidentiality is ensured. Thank you.

Name *(Last, First, M.I.):*		**DOB**:
Previous Family Physician:	**City:**	**Last Seen:**

CURRENT MEDICAL HISTORY

List Current Conditions (please use back of page if you need more room)

Physical:	
Emotional/Social:	

List the details of your prescription medications below (if unable to list, bring them with you to the clinic)

Prescription Medications – Name	Strength	Frequency Taken

List your non-prescription drugs (over-the-counter drugs, vitamins, herbs, etc)

List the details of allergies or side effects to medications below

Name of Medication	Reaction You Had

Please turn to next page

PAST MEDICAL HISTORY

Childhood Illness: Have you ever had chickenpox? ☐ Yes or ☐ No*

Immunizations: (Please include **dates**)		
	☐ Tetanus within past 10 years	☐ Pneumonia
	☐ Chickenpox*	☐ Hepatitis (Circle Type: A B Both Unsure)

Operations/Procedures Type of Operation or Procedure	Reason	Year

Other Hospitalizations Name of Hospital	Reason	Year

Other Major Past Problems/Injuries Description of Problem or Injury	Outcome	Year

Obstetrical History (Indicate number if any)

Total Pregnancies:	Term Deliveries:	Preterm Deliveries:
Miscarriages:	Pregnancy Terminations:	Living:

Obstetrical Complications:

FAMILY MEDICAL HISTORY

Please indicate relationship and approximate age of onset for blood relatives with any of the following conditions

Disease	**Relationship/ Approximate Age of Onset**
Heart disease	
High cholesterol	
Diabetes	
Asthma	
Stroke	
Dementia/Alzheimer's	
Osteoporosis	
Psychiatric problem	
Cancer (indicate type)	
Other	

Please turn to next page

SOCIAL HISTORY

Marital Status: Never Married Married Common Law Separated Divorced Widowed

Occupation (or Student Retired Disability Social Assistance):

Recreation/Hobbies:

Religion:

Lifestyle	Circle what best describes your diet:	VERY POOR	POOR	FAIR	GOOD EXCELLENT
	Circle what best describes your activity level:	MINIMAL	POOR	FAIR	GOOD EXCELLENT
Tobacco	Circle your smoking status:	NEVER SMOKED	SMOKER	EX-SMOKER	PASSIVE SMOKE CONTACT
	Cigarettes – #/day:	Year Stopped:		Total Years Smoked:	
Alcohol	Circle what best describes your drinking habits:	NONE	LIGHT	MODERATE	HEAVY EX-DRINKER
	How many drinks per day on average:	Year Stopped:			
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered cutting down?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Have you ever had a problem with alcohol?			☐ Yes	☐ No
Street Drugs	Circle what best describes your recreational drug use:	NEVER	EX-USER	LIGHT*	MOD* HEAVY*
	If yes, have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
	What drugs have you used?				
	How often do you usually use?			Date last used?	
Sex	Have you ever had sex?			☐ Yes	☐ No
	Are you sexually active now?			☐ Yes	☐ No
	If yes, what contraceptive method do you use if any?				
	Do you have any problems with infertility?			☐ Yes	☐ No
	Circle your sexual orientation:	HETEROSEXUAL	BISEXUAL	HOMOSEXUAL	UNKNOWN

PREVENTION AND WELLNESS

Preventive Screening Tests (Please give approximate dates for the following)*

Women only	(<70)	Date of last pap (recommended every 3 years):
	(>50)	Date of last mammogram (recommended every 2 years):
Both	(>50)	Date of last stool test for colon cancer (recommended every 2 years):
		Date of last cholesterol test:

Personal Health Goals

What areas of your life would you like to make changes in?

What changes have you made/are you making so far?

What help would you like?