Georgina
Nurse Practitioner-Led Clinic

Adult Registration Form

SECTION 1: PERSONAL INFORMATION- ALL AREA'S MUST BE COMPLETED

Current Date (MM/DD/YYYY):	
Do you reside in the Town of Georgina?	☐ Yes ☐ No
Legal Name	
Date of Birth (MM/DD/YYYY):	
Sex:	☐ Male ☐ Female
Home Address:	CITY POSTAL CODE
Phone:	Home: ( ) - Cell: ( ) -
Emergency Contact:	Name: Phone No:
Health Card Number:	Expiry date (MM/DD/YYYY):
E-mail address:	
Who is completing this form?	☐ Self ☐ Other - Name: Phone No: Relationship: ☐ Spouse ☐ Child ☐ Friend ☐ Other (specify):
Who has been your previous provider? Eg; Nurse Practitioner/Doctor?	Name: _____ Address: _____ Phone number: (___)_____-_____ Fax Number: (___)_____-_____ (Should you choose to become a patient of the clinic you would be required to give up your provider elsewhere.)
Pharmacy:	Name: _____ City: _____

SECTION 2: MEDICATIONS & ALLERGIES

List all medications that you use: (include all prescriptions, over the counter products, and supplements). If more than 5 please attach pharmacy list.

Current Medication **ie: Tylenol**	**What Strength?** **ie: 500mg**	**How many? How often?**

Do you have any drug allergies? ☐ Yes ☐ No

<u>If yes,</u> please list name of drug and specific reaction:

	Indicate Reaction			
Name of Drug	**Rash**	**Shortness of Breath**	**Nausea**	**Other (Specify)**

SECTION 3: PAST MEDICAL HISTORY

Which medical conditions do you have now or have you had in the past? *(Please check all that apply)*

Eye & Ear		
☐ Macular degeneration	☐ Cataracts	☐ Glaucoma
☐ Hearing loss/hearing aid(s)	☐ Other (specify):	

SECTION 3: PAST MEDICAL HISTORY – Continued

Heart		
☐ Heart attack, year: _____	☐ Heart failure	☐ High blood pressure
☐ Aortic stenosis	☐ Heart valve problem	☐ Angina
☐ High cholesterol	☐ Pacemaker	☐ Atrial fibrillation
☐ Irregular heartbeats (arrhythmias)	☐ Other (specify):	

Gastrointestinal Tract		
☐ Heartburn/reflux/GERD	☐ Ulcers	☐ Irritable bowel
☐ Liver disease/cirrhosis	☐ Hepatitis	☐ Gallbladder disease
☐ Colon polyps	☐ Bleeding problems	☐ Diverticulosis
☐ Constipation	☐ Hemorrhoids	☐ Celiac
☐ Other (specify):		

Bones & Joints		
☐ Gout	☐ Lower back pain	☐ Osteoporosis
☐ Rheumatoid Arthritis	☐ Arthritis	☐ Fractured bones
Location of above:		

Glands		
☐ Thyroid	☐ Thyroid overactive (high)	☐ Thyroid underactive (low)
☐ Diabetes	☐ Other (specify):	

SECTION 3: PAST MEDICAL HISTORY – Continued

Kidney & Urinary Tract		
☐ Frequent bladder infections	☐ Kidney disease	☐ Enlarged Prostate
☐ Urinary incontinence	☐ Kidney stones	
☐ Other (specify):		

Lungs		
☐ Asthma	☐ Bronchitis	☐ COPD/emphysema
☐ Recurrent pneumonias	☐ Other (specify):	

Nervous System		
☐ Dementia or Alzheimer's disease	☐ Parkinson's disease	☐ Epilepsy or seizures
☐ Neuropathy/nerve damage	☐ Stroke	
☐ Other (specify):		

Mental Health		
☐ Anxiety	☐ Depression	
☐ Other (specify):		

Cancers		
☐ Breast	☐ Prostate	☐ Colon/Rectum
☐ Lung	☐ Lymphatic	☐ Skin
☐ Other (specify):		

SECTION 3: PAST MEDICAL HISTORY – Continued

Other Health Problems		
☐ Hernia	☐ Anemia	☐ Thrombosis / blood clots
☐ Syncope (loss of consciousness)	☐ Sexual function problems (specify):	
☐ Other (specify):		

SECTION 4: SCREENING TESTS

TEST	DATE MOST RECENTLY DONE	RESULTS (IF RELEVANT)
Eye examination		
Hearing Test		
Bone Mineral Density (BMD)		
Colonoscopy		
Colon Cancer Check (FOBT or FIT)		
Fasting Bloodwork		

MEN ONLY

TEST	DATE MOST RECENTLY DONE	RESULTS (IF RELEVANT)
Prostate Exam (rectal exam)		
PSA blood test (prostate cancer screening)		
If you have ever smoked then an abdominal ultrasound to check for aortic aneurysm		

WOMEN ONLY

TEST	DATE MOST RECENTLY DONE	RESULTS (IF RELEVANT)
PAP test (cervical cancer)		
Mammogram		

SECTION 5: VACCINATIONS

Dates of your last vaccinations. (If you have record please bring with you)

Flu vaccine	Year:	Reaction: Yes / No
Pneumonia vaccine	Year:	Reaction: Yes / No
Tetanus booster	Year:	Reaction: Yes / No
Zostavax (Shingles)	Year:	Reaction: Yes / No

SECTION 6: SOCIAL HISTORY

Are you presently:	☐ Single/Never married ☐ Married ☐ Divorced/Separated ☐ Widowed
With whom do you live (please check all that apply):	☐ Alone ☐ Spouse or Partner ☐ Child ☐ Other family member (specify): _____ ☐ Others, not family (specify): _____
If living at a facility, please list the names of person and the contact number for medical treatment order:	
How many children do you have?	
Are you in regular contact with your children?	☐ No ☐ Yes
How much school did you complete?	☐ Less than 8th grade ☐ Some high school ☐ High school graduate ☐ Some college/university ☐ College/University graduate ☐ Graduate school
Are you presently working?	☐ Working full time ☐ Working part time ☐ Not working ☐ Retired
List your principal occupation and any other significant occupations:	

SECTION 7: LIFESTYLE

Do you drink alcohol, including beer and wine or hard liquor (i.e. vodka, whiskey, gin)?	☐ Daily ☐ A few times a week (specify number of days: ☐ Less than once a week ☐ Never
How much do you drink at a time? (One drink = 12oz of beer or 8-9oz of malt liquor or 5oz of table wine or 1.5oz of hard liquor)	☐ 1 drink ☐ 2 drinks ☐ 3 drinks ☐ 4 drinks ☐ 5 or more drinks ☐ None
Have you EVER smoked?	☐ Cigarettes ☐ Cigars ☐ Chew tobacco
Do you currently smoke cigarettes?	☐ No ☐ Yes **If no**, when did you quit? Year: _____ For how many years did you smoke? How many packs per day? ☐ ¼ ☐ ½ ☐ 1 ☐ 1½ ☐ 2+ **If yes**, how many packs per day? ☐ ¼ ☐ ½ ☐ 1 ☐ 1½ ☐ 2+ Would you like to quit? ☐ No ☐ Yes
Do you vape?	☐ No ☐ Yes; please specify amount, quantity and frequency _____
Do you use cannabis?	☐ No ☐ Yes; please specify amount, quantity and frequency _____
Do you use street drugs?	☐ No ☐ Yes; please specify amount, quantity and frequency _____

SECTION 8:

PLEASE LIST SPECIFIC HEALTH CONCERNS THAT YOU WOULD LIKE YOUR NURSE PRACTITIONER TO KNOW ABOUT BEFORE YOUR VISIT:

Please be sure to include any information not already reported in this form.

1.

2.

3.