



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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Legal Name	Preferred first name		
Date of Birth (MM/DD/YYYY):			
Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Gender Identification: (Optional)
Home Address:	CITY		POSTAL CODE
Phone:	Home: () -	Cell: () -	
Emergency Contact:	Name:	Phone No:	
Health Card Number:	Expiry date (MM/DD/YYYY):		
Who is completing this form?	<input type="checkbox"/> Self <input type="checkbox"/> Other - Name: Phone No: Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> 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

If yes, please list name of drug and specific reaction:

Name of Drug	Indicate Reaction			
	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		
<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Hearing loss/hearing aid(s)	<input type="checkbox"/> Other (specify):	

SECTION 3: PAST MEDICAL HISTORY – Continued

Heart		
<input type="checkbox"/> Heart attack, year: _____	<input type="checkbox"/> Heart failure	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Aortic stenosis	<input type="checkbox"/> Heart valve problem	<input type="checkbox"/> Angina
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Atrial fibrillation
<input type="checkbox"/> Irregular heartbeats (arrhythmias)	<input type="checkbox"/> Other (specify):	

Gastrointestinal Tract		
<input type="checkbox"/> Heartburn/reflux/GERD	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Irritable bowel
<input type="checkbox"/> Liver disease/cirrhosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Gallbladder disease
<input type="checkbox"/> Colon polyps	<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Constipation	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Celiac
<input type="checkbox"/> Other (specify):		

Bones & Joints		
<input type="checkbox"/> Gout	<input type="checkbox"/> Lower back pain	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fractured bones
Location of above:		

Glands		
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Thyroid overactive (high)	<input type="checkbox"/> Thyroid underactive (low)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other (specify):	

SECTION 3: PAST MEDICAL HISTORY – Continued

Kidney & Urinary Tract		
<input type="checkbox"/> Frequent bladder infections	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Enlarged Prostate
<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Kidney stones	
<input type="checkbox"/> Other (specify):		

Lungs		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> COPD/emphysema
<input type="checkbox"/> Recurrent pneumonias	<input type="checkbox"/> Other (specify):	

Nervous System		
<input type="checkbox"/> Dementia or Alzheimer's disease	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Epilepsy or seizures
<input type="checkbox"/> Neuropathy/nerve damage	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Other (specify):		

Mental Health		
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	
<input type="checkbox"/> Other (specify):		

Cancers		
<input type="checkbox"/> Breast	<input type="checkbox"/> Prostate	<input type="checkbox"/> Colon/Rectum
<input type="checkbox"/> Lung	<input type="checkbox"/> Lymphatic	<input type="checkbox"/> Skin
<input type="checkbox"/> Other (specify):		

SECTION 3: PAST MEDICAL HISTORY – Continued

Other Health Problems		
<input type="checkbox"/> Hernia	<input type="checkbox"/> Anemia	<input type="checkbox"/> Thrombosis / blood clots
<input type="checkbox"/> Syncope (loss of consciousness)	<input type="checkbox"/> Sexual function problems (specify):	
<input type="checkbox"/> 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:	<input type="checkbox"/> Single/Never married <input type="checkbox"/> Divorced/Separated	<input type="checkbox"/> Married <input type="checkbox"/> Widowed
With whom do you live (please check all that apply):	<input type="checkbox"/> Alone <input type="checkbox"/> Child <input type="checkbox"/> Other family member (specify): _____ <input type="checkbox"/> Others, not family (specify): _____	<input type="checkbox"/> Spouse or Partner
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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
How much school did you complete?	<input type="checkbox"/> Less than 8 th grade <input type="checkbox"/> High school graduate <input type="checkbox"/> College/University graduate	<input type="checkbox"/> Some high school <input type="checkbox"/> Some college/university <input type="checkbox"/> Graduate school
Are you presently working?	<input type="checkbox"/> Working full time <input type="checkbox"/> Not working	<input type="checkbox"/> Working part time <input type="checkbox"/> Retired
List your principal occupation and any other significant occupations:		

SECTION 7: LIFESTYLE

<p>Do you drink alcohol, including beer and wine or hard liquor (i.e. vodka, whiskey, gin)?</p>	<p><input type="checkbox"/> Daily</p> <p><input type="checkbox"/> A few times a week (specify number of days: _____)</p> <p><input type="checkbox"/> Less than once a week</p> <p><input type="checkbox"/> Never</p>
<p>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)</p>	<p><input type="checkbox"/> 1 drink <input type="checkbox"/> 2 drinks</p> <p><input type="checkbox"/> 3 drinks <input type="checkbox"/> 4 drinks</p> <p><input type="checkbox"/> 5 or more drinks <input type="checkbox"/> None</p>
<p>Have you EVER smoked?</p>	<p><input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars</p> <p><input type="checkbox"/> Chew tobacco</p>
<p>Do you currently smoke cigarettes?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If no, when did you quit? Year: _____</p> <p>For how many years did you smoke?</p> <p>How many packs per day? <input type="checkbox"/> ¼ <input type="checkbox"/> ½ <input type="checkbox"/> 1 <input type="checkbox"/> 1½ <input type="checkbox"/> 2+</p> <p>If yes, how many packs per day? <input type="checkbox"/> ¼ <input type="checkbox"/> ½ <input type="checkbox"/> 1 <input type="checkbox"/> 1½ <input type="checkbox"/> 2+</p> <p>Would you like to quit? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>Do you vape?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes; please specify amount, quantity and frequency</p> <p>_____</p>
<p>Do you use cannabis?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes; please specify amount, quantity and frequency</p> <p>_____</p>
<p>Do you use street drugs?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes; please specify amount, quantity and frequency</p> <p>_____</p>

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.